

Name _____ Date of Birth _____

How did you hear about Bay Radiology? _____

Reason for today's exam:

- Screening mammography (no symptoms or problems)
- Diagnostic imaging (problem solving exam)

Last menstrual cycle date: _____

Reason for today's diagnostic study:

- Follow-up Breast Cancer R L _____
- Palpable Lump R L _____
- Nipple Discharge R L _____
- Breast Pain R L _____
- Follow-up Prior Imaging R L _____

Risk factors for breast cancer (if you check yes, please explain):

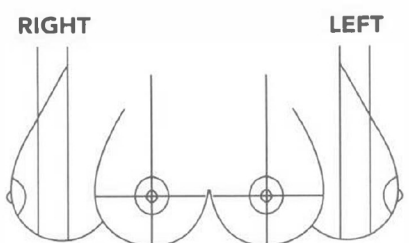
- Y N Have you had Breast Cancer? _____
- Y N Family history of Breast Cancer? _____
- Hormone use? _____
- Your age when your first child was born? _____

Have you had any of the following breast procedures? If yes, please indicate right (R) or left (L) breast.

			When	Result
<input type="radio"/> Y <input type="radio"/> N	Biopsy	<input type="radio"/> R <input type="radio"/> L	_____	_____
<input type="radio"/> Y <input type="radio"/> N	Resection (i.e., Lumpectomy)	<input type="radio"/> R <input type="radio"/> L	_____	_____
<input type="radio"/> Y <input type="radio"/> N	Radiation to Chest	<input type="radio"/> R <input type="radio"/> L	_____	_____
<input type="radio"/> Y <input type="radio"/> N	Breast Implants	<input type="radio"/> R <input type="radio"/> L	_____	_____
<input type="radio"/> Y <input type="radio"/> N	Breast Reduction or Lift	<input type="radio"/> R <input type="radio"/> L	_____	_____

Patient Signature: _____ Date: _____

FOR OFFICE USE ONLY



Technologist Notes: _____

Technologist Signature: _____ Date: _____