Pink Door Imaging

BREAST & GYNECOLOGICAL IMAGING

PATIENT INFORMATION

PATIENT NAME: _____ DOB : _____

REASON FOR VISIT ○ ***Screening*** *(no current problems)* ***Diagnostic*** ○ *(Breast problem) & (follow up)*

Name of Physician ON ORDERS: _____ □ *(Self-Referral) (No orders)*

YEAR & DATE OF LAST MAMMOGRAM:

_____

Age/first menstrual _____ Pregnant ○Y ○N Currently on birth control ○Y ○N Currently on hormones ○Y ○N

Your Age with first child? _____ #of births_____ Hysterectomy ○Y ○N Ovaries removed ○Y ○N

Breast Implants: ○ Y ○N Original year____ Replaced Year____ Reduction(R) (L) Year ____

Surgical Biopsy? ○ Left ○Right ○ Both Year_____ Needle Biopsy? ○ Left ○Right ○Both Year _____

Family history of breast/ovarian cancer ○Y ○N **Family Relation** & **Age** of Diagnosis ***List below***:

_____

Personal History of Breast Cancer ○ Y ○N IF "YES" **CHECK ONE:** ○Lumpectomy○ Radiation ○Mastectomy Chemotherapy○ Hormone Therapy

Screening Mammogram appointments with any symptoms BELOW WILL BE RESCHEDULED & will require a Physicians Orders.

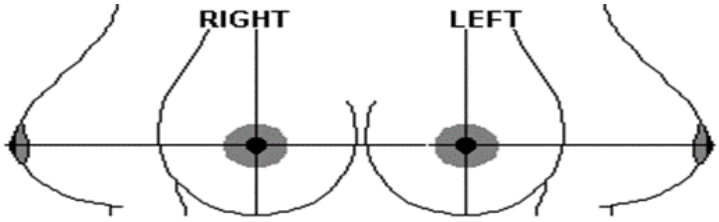
Please check any ONLY *CURRENT* Symptoms TODAY

○Lump ○Tenderness ○Discharge ○Skin change ○Thickening ○Pain ○Nipple Inversion

Please list duration of time _____Is Referring Physician aware of symptoms ○Y ○N

Patient Signature: _____ Date: _____

********************STAFF USE BELOW***************************



BC#_____ ○ SCREENING ○ DX ○RIGHT ○LEFT ○BILATERAL ○IMPLANT