

MAMMOGRAPHY QUESTIONNAIRE

Patient Name: _____ Date of Birth: _____

Physician: _____ When was your last Clinical Breast Exam? _____

Is this your first mammogram? **YES** ____ **NO** ____ If not, When and Where was your last mammogram?

Date: _____ - Place: _____

PLEASE COMPLETE THE MEDICAL RELEASE FORM ON THE OTHER SIDE OF THIS FORM

Are you having any problems with your breasts? _____

If YES, Please check the following symptoms you currently have:

LUMP OR THICKENING	RIGHT ____	LEFT ____	INFECTION OR INFLAMATION	RIGHT ____	LEFT ____
PAIN OR TENDERNESS	RIGHT ____	LEFT ____	RECENT BREAST INJURY	RIGHT ____	LEFT ____
NIPPLE DISCHARGE	RIGHT ____	LEFT ____	DISCHARGE COLOR	_____	
NIPPLE ABNORMALITY	RIGHT ____	LEFT ____	FIBROCYSTIC CHANGE	RIGHT ____	LEFT ____
LARGE LYMPH NODES	RIGHT ____	LEFT ____	OTHER	_____	

Have you had breast cancer? _____ If YES, in which breast? _____

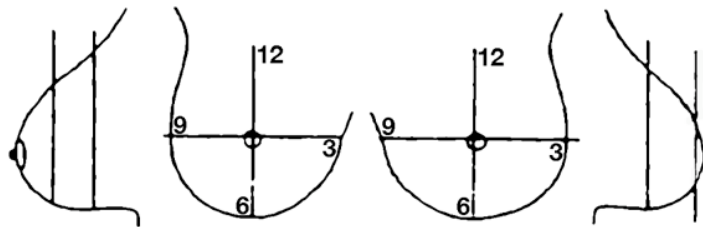
Have you had any other type of cancer ? _____ If YES, Please list the type: _____

FAMILY HISTORY OF BREAST CANCER: Please list any relatives that have had breast cancer.

Mother ____ Daughter ____ Sister ____ Son ____ Father ____ Brother ____ Grandmother ____
Aunt ____ Cousin ____ Other _____

PLEASE CHECK ANY OF THE FOLLOWING PROCEDURES YOU HAVE HAD:

Implants	RIGHT ____	LEFT ____	TYPE: <input type="checkbox"/> SALINE <input type="checkbox"/> SILICON <input type="checkbox"/> DON'T KNOW
Breast MRI	RIGHT ____	LEFT ____	
Cyst Aspiration	RIGHT ____	LEFT ____	
Needle Biopsy	RIGHT ____	LEFT ____	
Surgical Biopsy	RIGHT ____	LEFT ____	
Breast Reduction	RIGHT ____	LEFT ____	
Lumpectomy (Cancer)	RIGHT ____	LEFT ____	
Mastectomy (Cancer)	RIGHT ____	LEFT ____	
Reconstruction	RIGHT ____	LEFT ____	



Right **Left**

Have you had chemotherapy? _____
Have you had radiation therapy? _____
Have you taken Tamoxifen or Evista? _____

GYNECOLOGY HISTORY:

Are you pregnant? YES NO Last Period: _____ Are you taking birth control pills? _____
Have you had a hysterectomy? _____ Age: _____ Were your ovaries removed? YES NO
Are you currently taking hormones? _____ Have you ever taken hormones? _____
How many times have you been pregnant? _____ Number of live births: _____
Age when you delivered your 1st live birth? _____ Age at last delivered live birth? _____
I have been pregnant but never delivered a live birth _____

I attest that the information I have provided on this form is true to the best of my knowledge

Signature of Patient or person authorized to consent for patient _____ Date _____ Tech _____

AUTHORIZATION FOR RELEASE OF PRIVATE HEALTH INFORMATION

To: _____

Address: _____

City, State, Zip Code: _____

Phone: _____ Fax: _____

I hereby request that my Private Health Information be released to:

**THE BREAST CENTER OF NWA
55 W. SUNBRIDGE
FAYETTEVILLE, AR 72703**

Phone: 479-442-6266 Fax: 479-521-3877

**Specific information to be released to the above referenced entity:
PLEASE SEND ALL BREAST IMAGING REPORTS, FILMS AND ANY PATHOLOGY FOR THE
LAST TWO EXAMS OR LAST TWO YEARS DONE AT YOUR FACILITY**

This Authorization shall be deemed to expire on the earlier of one (1) year from the date set forth next to my signature or within reasonable time following completion of the event which gave rise to the purpose of this Authorization.

I understand that I have the right to revoke this Authorization in writing at any time and that I may do so by delivering a revocation in writing to the Clinic.

I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the receiving entity and may no longer be protected by the Privacy Standards of this Clinic. The Clinic has informed me that the Clinic will not condition treatment, payment, enrollment or eligibility for benefits on obtaining this authorization.

Patient Name (PRINT) : _____ **D.O.B.** _____

Signature: _____ **Date:** _____

In the event the Authorization is being executed by a personal representative, guardian, or parent, please print your name and relationship to the patient.

Name: _____ Date: _____

Relationship to Patient: _____