



**the breast center**  
OF NORTHWEST ARKANSAS

Imaging Associates of Northwest Arkansas  
Medical Associates of Northwest Arkansas, P.A.

Patient Name: \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age: \_\_\_\_\_

Physician: \_\_\_\_\_

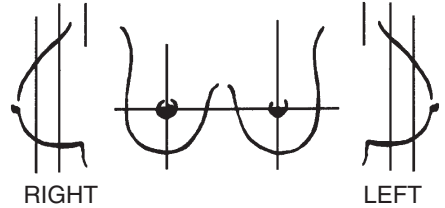
When did your doctor do your last breast exam? \_\_\_\_\_

Is this your first mammogram?  Yes  No If no, when was your last mammogram done? \_\_\_\_\_

Name and address of office or hospital where mammogram was done: \_\_\_\_\_

**If you are having any problems with your breasts, circle the symptoms in this section:**

Lump or thickening	RT	LT	BOTH	Infection / inflammation	RT	LT	BOTH
Pain / tenderness	RT	LT	BOTH	Recent breast injury	RT	LT	BOTH
Nipple discharge	RT	LT	BOTH	Discharge color: _____			
Nipple abnormality	RT	LT	BOTH	Fibrocystic change:	RT	LT	BOTH
Large lymph node	RT	LT	BOTH	Other _____			



How long have you had these symptoms? \_\_\_\_\_

**Have you had breast cancer?**  Yes  No If yes, answer questions in this section (please circle)

Which breast? RT LT BOTH When were you diagnosed? \_\_\_\_\_

If yes, please circle which treatments you have had done:

Lumpectomy	RT	LT	BOTH	Radiation	RT	LT	BOTH
Mastectomy	RT	LT	BOTH	Chemotherapy	RT	LT	BOTH
Reconstruction	RT	LT	BOTH	Tamoxifen or Evista?	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Type of reconstruction: \_\_\_\_\_

**Do you have implants?**  Yes  No If yes: RT LT BOTH **Type?** Saline Silicone Don't know

**Please circle any of the following procedures you have had done:**

Breast MRI	RT	LT	BOTH	Needle biopsy	RT	LT	BOTH
Cyst aspiration	RT	LT	BOTH	Surgical biopsy	RT	LT	BOTH
Breast reduction	RT	LT	BOTH	None			

**Has anyone in your family had breast cancer?**  Yes  No If yes, please check below:

Mother \_\_\_\_\_  Sister \_\_\_\_\_  Daughter \_\_\_\_\_  Grandmother \_\_\_\_\_  
 Aunt \_\_\_\_\_  Niece \_\_\_\_\_  Female cousin \_\_\_\_\_  
 Father  Brother  Son  Grandfather  Uncle  Nephew  Male cousin

**Have you had ovarian cancer?**  Yes  No If yes, when were you diagnosed? \_\_\_\_\_

**Has anyone in your family had ovarian cancer?**  Yes  No If yes, specify: \_\_\_\_\_

**Gynecological history:** Please circle/answer the following that apply to you

**Are you pregnant?**  Yes  No  Don't know

If you are still having periods, when was your last one? \_\_\_\_\_

If not, have you gone through menopause?  Yes  No  Don't know If yes, age: \_\_\_\_\_

Have you had a hysterectomy?  Yes  No If yes, ovaries removed?  Yes  No Age: \_\_\_\_\_

Are you currently taking hormones or birth control pills?  Yes  No

If no, have you ever taken them?  Yes  No When did you stop taking them? \_\_\_\_\_

Name of hormone or birth control pill: \_\_\_\_\_

How many times have you been pregnant? \_\_\_\_\_ How many live births have you had? \_\_\_\_\_

Your age when you delivered 1st live birth? \_\_\_\_\_ Age at last live birth? \_\_\_\_\_

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

Signature of the patient or person authorized to consent for patient

Date

Tech Initials

**AUTHORIZATION FOR RELEASE OF PRIVATE HEALTH INFORMATION**

TO: \_\_\_\_\_  
Name of radiology office or hospital where images were taken

\_\_\_\_\_  
ADDRESS

\_\_\_\_\_  
CITY, STATE, ZIP CODE

\_\_\_\_\_  
PHONE

\_\_\_\_\_  
FAX

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



**the breast center**  
OF NORTHWEST ARKANSAS

55 Sunbridge  
Fayetteville, AR 72703

Phone: 479.442.6266  
Fax 479.521.3877

**SPECIFIC INFORMATION TO BE RELEASED:**

**PLEASE SEND THE LAST 2 YEARS OF BREAST IMAGING FILMS ALONG WITH ALL BREAST IMAGING REPORTS AND PATHOLOGY REPORTS YOU HAVE ON FILE.**

PATIENT NAME (print) \_\_\_\_\_ D.O.B. \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

This authorization shall be deemed to expire on the earlier of 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.

I understand that I may refuse to sign this Authorization.

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

REPRESENTATIVE NAME: (print) \_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_