

DELANEY RADIOLOGISTS BREAST IMAGING PATIENT REGISTRATION FORM

Patient Name: _____ Today's Date: _____ Age: _____

Date of Birth: _____ Referring Physician: _____

Telephone: _____ Secondary Telephone #: _____

Any Prior Breast Imaging (Mammography / Ultrasound / MRI)? Yes No

If yes, where? _____ When? _____

Date / year of your last menstrual period: _____ Are you on hormones? Yes No

Is there any possibility you could be pregnant? Yes No

Has your mother or sister(s) had cancer of the breast? Yes No

If yes, was it before the age of 50? Yes No

Do you have a personal history of cancer of the breast? Yes No

If yes, which breast and when? _____

Are you having any problems with your breasts today? Yes No

If yes, please explain _____

Have you ever had any breast surgery? Yes No

If yes, what type of surgery?

Implants Date(s) of Surgery _____

Reduction Date(s) of Surgery _____

Biopsy Date(s) of Surgery _____ Right or Left _____

For patients with a history of breast cancer:

Mastectomy Date(s) of Surgery _____ Right or Left _____

Lumpectomy Date(s) of Surgery _____ Right or Left _____

Patient's Signature _____ Date: _____

FOR TECHNOLOGIST USE ONLY

Notes: _____

_____ :

Technologist

