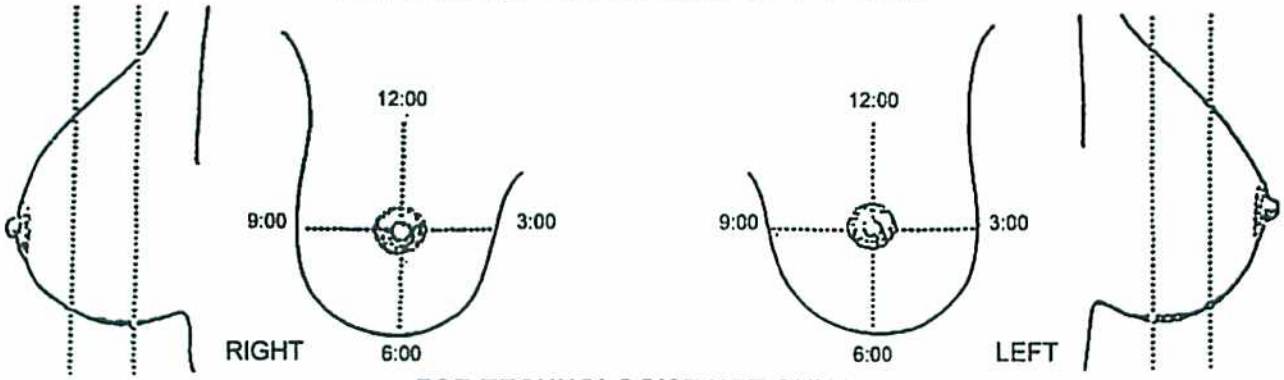
Delaney # _____

DELANEY RADIOLOGISTS
BREAST IMAGING HISTORY FORM



FOR TECHNOLOGIST USE ONLY

Notes: _____

_____

_____ : _____
Technologist

PATIENT TO FILL OUT THE FOLLOWING INFORMATION

Patient Name: _____ Referring Physician: _____

Date of Birth: _____ Age: _____

Phone #: _____ Alternate Phone #: _____

Last mammogram performed at ☐ Delaney ☐ Other Facility: Name_____Year_____

Is there any possibility you could be pregnant? ..... ☐ Yes ☐ No

Are you on hormones? ..... ☐ Yes ☐ No

Have you personally had cancer of the breast? ..... ☐ Yes ☐ No

If yes, which breast?_____When? _____

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 _____
- ☐ Cyst Aspiration Date(s) of Surgery _____ Right or Left _____
- ☐ Biopsy Date(s) of Surgery _____ Right or Left _____
- ☐ Lumpectomy Date(s) of Surgery _____ Right or Left _____
- ☐ Mastectomy Date(s) of Surgery _____ Right or Left _____
- ☐ Reconstruction Date(s) of Surgery _____ Right or Left _____

ARE YOU HAVING ANY NEW PROBLEMS WITH YOUR BREASTS TODAY? ..... ☐ Yes ☐ No

If yes, please explain _____

(If you have any current symptoms or if your physician is following up on any prior finding, your mammogram will be coded as diagnostic rather than screening.)

Patient's Signature _____ Date: _____

REV 9/15