Touchstone
MEDICAL IMAGING

Today's Date:___________________________

Name:____**Date of Birth:**____________________

Referrring Physician:____________________________________Other Physicians who should get a copy:_____________________________

If you have any questions about this form, your technologist will be able to help you during your exam.

Have you had a mammogram before? **YES NO If so, when and where?**____

Do you take hormones or birth control pills? **YES NO If so, for how long?**____

Are you still having menstrual periods? **YES NO If so, when was your last?**_______________________________________

Have you been through menopause? **YES NO If YES, was it naturally or due to Hysterectomy?**______________________

Do you have implants? **YES NO If YES, what type of implants do you have? SALINE OR SILICONE**

Which breast? LEFT RIGHT Lumpectomy Mastectomy Radiation Chemotherapy

Have you had Ovarian Cancer? **YES NO If so, when?**____

Have any of your family members had Breast or Ovarian Cancer? **YES NO (Please list which cancer and the ages which they were diagnosed.)**____

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What breast procedures/surgeries have you had (including needle biopsies, implants, and reduction surgery) and when?

RT LT When?____

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Are you having any promblems with your breast: Lump(s), pain or discomfort, or nipple discharge? (Please list problems)

RT LT How long:____

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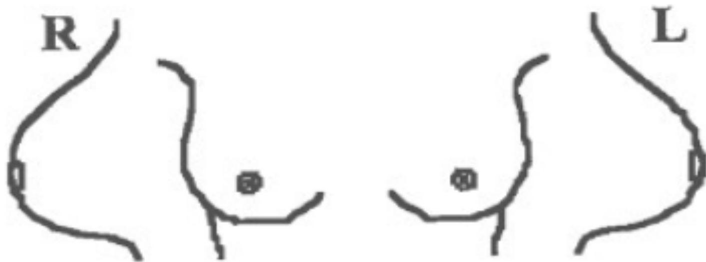
By signing this form below, I consent to the mammography exam and acknowledge that I am neither pregnant nor breast-feeding.

Patient Signature:____**Print Name:**____________________________________



Technologist:____

Technologist Notes: ____

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