Touchstone MEDICAL IMAGING

Screening Mammography Patient Information

Name: _____ Date of Birth: _____

Who is your doctor: _____

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? _____

Do you think you may be pregnant?

❑ **YES** ❑ **NO**

Date of last menstrual cycle _____/_____/_____

Are you breastfeeding or have you breastfed within the last 6 months?

❑ **YES** ❑ **NO**

Have you had breast cancer?

❑ **YES** ❑ **NO**

Did you receive Radiation Therapy to that breast?

❑ **YES** ❑ **NO**

Have any of your **blood** relatives had Breast Cancer?

❑ **YES** ❑ **NO**

Who? _____

Any blood relative diagnosed with breast cancer before age 45?

❑ **YES** ❑ **NO Who?** _____

Any males with breast cancer?

❑ **YES** ❑ **NO Who?** _____

Have you ever had breast surgery including needle biopsy, surgical biopsy, lumpectomy, breast implants, mastectomy or breast reduction?

❑ **YES** ❑ **NO** **Side:** ❑ **RT** ❑ **LT**

Type: _____ **When?** _____

Have you or any of your **blood** relatives had ovarian or fallopian tube cancer?

❑ **YES** ❑ **NO**

Who? _____

Do you have a personal or family history of pancreatic cancer?

❑ **YES** ❑ **NO**

Who? _____

Have any of your family members been identified to carry a gene mutation associated with hereditary cancer (e.g. BRCA1, BRCA2, TP53, PTEN, etc.)?

❑ **YES** ❑ **NO**

Are you of Ashkenazi Jewish ancestry?

❑ **YES** ❑ **NO**

Have you received genetic counseling or genetic testing for breast cancer?

❑ **YES** ❑ **NO**

When? _____ ❑ **POS** ❑ **NEG**

Do you currently have nipple discharge **that has not been previously evaluated?**

❑ **YES** ❑ **NO**

Side: ❑ **RT** ❑ **LT** **Spontaneous:** ❑ **YES** ❑ **NO**

Color: _____ **How Long?** _____

Do you or your physician currently feel a **new** lump that has not been evaluated?

❑ **YES** ❑ **NO**

Side: ❑ **RT** ❑ **LT** **How Long?** _____

Do you have any other **new** breast problems?

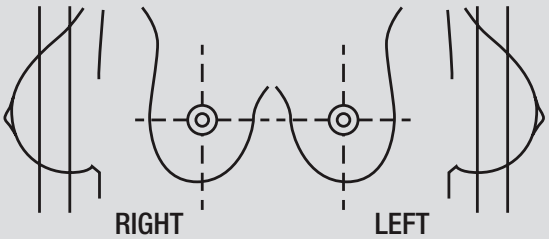
❑ **YES** ❑ **NO**

Describe: _____

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

Patient Signature _____ Today's Date: _____

FOR TECHNOLOGIST USE ONLY:



Technologist: _____

❍ 2D ❍ 3D

❍ BILAT ❍ RIGHT ❍ LEFT

Comments: _____

_____

_____

_____

_____

_____

_____

Touchstone
MEDICAL IMAGING

MAMMOGRAPHY AND BONE DENSITY

Authorization to Disclose my Protected Health Information (PHI) for Diagnostic Follow up

I realize that follow-up diagnostic imaging may be required, based on the results of my screening mammogram. I understand that, at this time, Touchstone Medical Imaging Mammography/Bone Density only offers screening mammograms, along with DEXA's.

If a Diagnostic follow-up exam for a Mammogram is indicated, I give my consent for Lutheran's Breast Care Center at Lutheran Medical Center, to contact me directly and/or leave a message stating the type of exam needing to be scheduled for the follow-up Diagnostic Appointment.

I give Touchstone Medical Imaging the following authority to forward my protected health information (PHI) for my continuation of care:

Please choose an option below:

- ❑ I understand that Touchstone Imaging, Mammography, is in partnership with Lutheran Medical Center. I prefer to keep any Diagnostic Imaging follow up care with Lutheran Medical Center and allow my records to be shared with Lutheran Medical Center for any ongoing care.
- ❑ I prefer to have my diagnostic follow-up care at an alternate location: I hereby allow my records to be shared with

  _____

  (patient to specify name and contact information of imaging facility) for follow up and diagnostic imaging.

By signing below, I understand the disclosure of my PHI is necessary for my follow-up care. Should I need to change my desired location, I give Touchstone Medical Imaging the approval to do so upon myself or my physicians' verbal or written request.

_____ _____

Patient Signature Date