MD Imaging
a Rezolut partner

MAMMOGRAPHY QUESTIONNAIRE

NOTE: If you are wearing deodorant or powder, please inform the technologist.

Name: _____ DOB: _____ Age: _____

Referring MD: _____ Ethnicity: _____

Have you had a mammogram before? Yes☐ No☐

Where and when: _____

Reason for today's exam: Routine, lump, pain, discharge, follow up_____

Date of last Clinical breast exam (physical breast exam by your doctor) _____

Is there any history of breast cancer in yourself or family? Yes☐ No☐

If so, Whom? _____ At what age? _____

Are you pregnant? _____ Have you breast fed in past 3 months? _____

Have you had a child? _____ Your age at first child's birth_____

Your age at first menstruation_____ Your age at menopause_____

Do you take hormones such as: Estrogen, Premarin, Provera, Birth Control, Synthroid, Tamoxifen? Yes No

Which type? _____ Duration? _____

Have you gained_____ or lost_____ weight since your last mammogram? How much? _____ lbs

Have you had any breast surgery? (Circle all that apply) ☐Yes ☐No biopsy aspiration implants reduction

Describe_____When_____ Where_____

_____

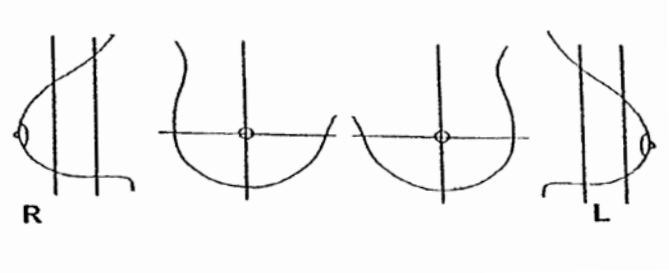
Any radiation to the chest (e.g. Hodgkin's or non-Hodgkin's lymphoma)? Yes____ No____

Patient Signature _____Date_____

========== To be filled out by Technologist ==========

Nipples inverted? R L How long? _____

Breast size difference? _____



Lifetime risk (Pt.) _____% Average_____% Technologist Initials _____

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Call Back Authorization

It is sometimes necessary for a patient to be called back for additional imaging (extra mammo views/ultrasound). This does not necessarily mean a problem has been detected, but that additional images are necessary to complete the exam. If we cannot reach you by phone directly, do we have your permission to leave a message on your answering machine regarding the needed call back?

Yes_____ No_____

Phone number (home/cell etc)_____
Under current HIPAA regulations, we are not allowed to leave a detailed message unless we have your permission.

Signature_____ Date_____

Medical Release Authorization

MD IMAGING
14 Raymond Avenue Poughkeepsie NY 12603
1323 Rte 9, Suite 107, Wappingers Falls, NY 12590
Tel: 845-471-2848 Fax: 845-471-2919

I hereby authorize the release to MD Imaging, any information, including but not limited to, records, films, diagnosis and reports.

Medical Records Release:

_____
_____
_____

_____ _____
Signature Date

_____
Print Name