

MAMMOGRAPHY PATIENT INFORMATION

(This form is subject to the Privacy Act of 1974. Use blanket PAS-DD Form 2005)

Last name	FMP/Sponsor SSN
First name	DOB (MM/DD/YY)
Address	Age
City, State, ZIP	Sex <input type="checkbox"/> female <input type="checkbox"/> male
Home Phone	Work Phone

*******PLEASE COMPLETE THIS SIDE ONLY*******

Have you had a previous mammogram? <input type="checkbox"/> yes <input type="checkbox"/> no If yes, when and where? _____	
Are you pregnant? <input type="checkbox"/> yes <input type="checkbox"/> no	First day of last menstrual period: _____
Method of birth control : _____ Signature: _____	
Number of full term pregnancies: _____	Age at first pregnancy: _____
Age when menstruation began: _____	Age at menopause: _____
Have you ever used Hormone Replacement Therapy (HRT)? <input type="checkbox"/> yes <input type="checkbox"/> no If yes, for how long? _____	
If yes, are you still using HRT? <input type="checkbox"/> yes <input type="checkbox"/> no If no, when did you stop? _____	
Have you had a hysterectomy? <input type="checkbox"/> yes <input type="checkbox"/> no If yes, was it for gynecological cancer? <input type="checkbox"/> yes <input type="checkbox"/> no At what age? _____	
Have you had your ovaries removed? <input type="checkbox"/> yes <input type="checkbox"/> no If yes, which one? <input type="checkbox"/> right <input type="checkbox"/> left <input type="checkbox"/> both At what age? _____	
Do you have a family history of breast cancer? <input type="checkbox"/> yes <input type="checkbox"/> no	
If yes, check all that apply: <input type="checkbox"/> mother <input type="checkbox"/> grandmother <input type="checkbox"/> sister <input type="checkbox"/> aunt <input type="checkbox"/> daughter <input type="checkbox"/> cousin	
Was relative postmenopausal? <input type="checkbox"/> yes <input type="checkbox"/> no	
Do you have breast implants? <input type="checkbox"/> yes <input type="checkbox"/> no If yes please mark: <input type="checkbox"/> saline <input type="checkbox"/> silicone Year of surgery: _____	
Have you had any of the following:	
Chemotherapy for <i>breast cancer</i> ----- <input type="checkbox"/> yes <input type="checkbox"/> no If yes, when? _____ For how long? _____	
Cyst aspiration ----- <input type="checkbox"/> yes <input type="checkbox"/> no If yes, which side? <input type="checkbox"/> right <input type="checkbox"/> left <input type="checkbox"/> both When? _____	
Needle biopsy ----- <input type="checkbox"/> yes <input type="checkbox"/> no If yes, which side? <input type="checkbox"/> right <input type="checkbox"/> left <input type="checkbox"/> both When? _____	
Excisional biopsy ----- <input type="checkbox"/> yes <input type="checkbox"/> no If yes, which side? <input type="checkbox"/> right <input type="checkbox"/> left <input type="checkbox"/> both When? _____	
Lumpectomy ----- <input type="checkbox"/> yes <input type="checkbox"/> no If yes, which side? <input type="checkbox"/> right <input type="checkbox"/> left <input type="checkbox"/> both When? _____	
Mastectomy ----- <input type="checkbox"/> yes <input type="checkbox"/> no If yes, which side? <input type="checkbox"/> right <input type="checkbox"/> left <input type="checkbox"/> both When? _____	
Radiation therapy for <i>breast cancer</i> --- <input type="checkbox"/> yes <input type="checkbox"/> no If yes, which side? <input type="checkbox"/> right <input type="checkbox"/> left <input type="checkbox"/> both When? _____	
Present complaint/reason for exam: _____	

******* GENERAL EXAM INFORMATION – TECHNOLOGIST SECTION *******

<u>Procedure:</u> <input type="checkbox"/> M-SCR <input type="checkbox"/> M-DIAG <input type="checkbox"/> M-UNI <input type="checkbox"/> STFU <input type="checkbox"/> AV <input type="checkbox"/> US <input type="checkbox"/> IMPLA <input type="checkbox"/> OC <input type="checkbox"/> OTHER _____ DATE: _____ PHYSICIAN: _____	<u>Radiologist:</u> <input type="checkbox"/> ABRAW <input type="checkbox"/> MEDUD <input type="checkbox"/> NUSSC <input type="checkbox"/> MIDDP <input type="checkbox"/> DUNNT <input type="checkbox"/> <u>Technologist:</u> <input type="checkbox"/> HOLDJ <input type="checkbox"/> WALTJ <input type="checkbox"/> BATZP <input type="checkbox"/> _____
<u>Reason for study:</u> <input type="checkbox"/> [S] Screening <input type="checkbox"/> [P] Problem indicated <input type="checkbox"/> [A] Additional eval requested from prior study <input type="checkbox"/> [V] Additional eval requested from current Hx breast	<input type="checkbox"/> [1] Follow up of previous BX ____/____/____ <input type="checkbox"/> [O] Review of outside study / addendum reading <input type="checkbox"/> [R] Pre-reduction mammoplasty <input type="checkbox"/> [T] Pre- radiation therapy <input type="checkbox"/> [H] History of breast augmentation, asymptomatic
<u>Indicated problems:</u> <input type="checkbox"/> [A] Palpable abnormality <input type="checkbox"/> [R] [L] [B] <input type="checkbox"/> [B] Bloody discharge <input type="checkbox"/> [R] [L] [B] <input type="checkbox"/> [D] Non-bloody discharge <input type="checkbox"/> [R] [L] [B] <input type="checkbox"/> [W] Cancer elsewhere <input type="checkbox"/> [R] [L] [B] <input type="checkbox"/> [K] Skin thickening or retraction <input type="checkbox"/> [R] [L] [B]	<input type="checkbox"/> [I] Breast implant problem <input type="checkbox"/> [R] [L] [B] <input type="checkbox"/> [L] Lump or thickening <input type="checkbox"/> [R] [L] [B] <input type="checkbox"/> [N] Nipple abnormality <input type="checkbox"/> [R] [L] [B] <input type="checkbox"/> [P] Pain <input type="checkbox"/> [R] [L] [B] <input type="checkbox"/> [X] Large axillary lymph nodes <input type="checkbox"/> [R] [L] [B] <input type="checkbox"/> [E] Difficult physical examination <input type="checkbox"/> [R] [L] [B]
<u>Risk Factors:</u> <input type="checkbox"/> [C] Personal breast cancer hx <input type="checkbox"/> hysterectomy <input type="checkbox"/> [G] Personal GYN cancer hx <input type="checkbox"/> HRT <input type="checkbox"/> [H] Hx high-risk lesion on previous bx <input type="checkbox"/> [Q] Postmenopausal patient <input type="checkbox"/> [U] Nulliparous	<input type="checkbox"/> [Z] Late child bearing (<i>after 30</i>) <input type="checkbox"/> [0] No family history of breast cancer <input type="checkbox"/> [1] Weak family history of breast cancer <input type="checkbox"/> [2] Intermediate risk from family history <input type="checkbox"/> [3] Very strong family history of breast cancer <input type="checkbox"/> [4] Unknown family history

*******RADIOLOGIST SECTION *******

<u>Ultrasound:</u> <input type="checkbox"/> yes <input type="checkbox"/> no	<u>Results:</u> <input type="checkbox"/> normal (not seen sonographically) <input type="checkbox"/> simple cyst <input type="checkbox"/> complex cyst <input type="checkbox"/> intracystic lesion <input type="checkbox"/> solid
<u>Impression:</u> <input type="checkbox"/> [0] Needs add'l imaging <input type="checkbox"/> [1] Negative <input type="checkbox"/> [2] Benign <input type="checkbox"/> [3] Probably benign <input type="checkbox"/> [4] Suspicious <input type="checkbox"/> [5] Malignant	<u>Follow-up recommendation:</u> <input type="checkbox"/> [N] Normal screening interval; follow ACS <input type="checkbox"/> [N2] Normal screening interval; active duty <input type="checkbox"/> [1] 1 year follow-up <input type="checkbox"/> [F6] 6 month follow-up <input type="checkbox"/> [F3] 3 month follow-up <input type="checkbox"/> [L] Needle localization and biopsy <input type="checkbox"/> [B] Biopsy should be considered <input type="checkbox"/> [O] Need outside films <input type="checkbox"/> [T] Take appropriate action if highly suggestive of malignancy <input type="checkbox"/> [D] Any decision to biopsy should be based on clinical assessment <input type="checkbox"/> [U] Ultrasound <input type="checkbox"/> [P] Additional projections <input type="checkbox"/> [S] Spot compression <input type="checkbox"/> [M] Magnifications <input type="checkbox"/> [H] Histology using core biopsy <input type="checkbox"/> [Y] Cytological analysis FU Date override (MM/YY) ____/____
<u>Review/multiple readings:</u> <input type="checkbox"/> other	<input type="checkbox"/> [1] diagnosis agreement <input type="checkbox"/> [2] diagnosis disagreement <input type="checkbox"/> [3] significant diagnosis disagreement Reviewing doctor (<i>initials</i>) _____ Bill # _____