

PLEASE FILL OUT AND BRING WITH YOU TO YOUR APPOINTMENT

NAME: _____ **Date of Birth:** ___/___/___ Are you or could you be pregnant? **No** **Yes**

Date (Month/Year) _____ of **last physical breast exam** by your physician

Most Recent Breast Imaging

Please circle

NONE or

Mammogram: Date: _____ Facility: _____

Ultrasound: Date: _____ Facility: _____

MRI: Date: _____ Facility: _____

Current Breast Problems

Please circle

NONE or

Lump **Right** **Left**

Tenderness-Not related to menstrual cycle **Right** **Left**

Nipple Discharge **Right** **Left**

Other (Injury, Skin Changes, dimpling, etc) _____

Have you ever been diagnosed with Breast Cancer (including DCIS)?

Please circle

YES→ **Right** **Left** If yes, treatment? Lumpectomy _____ Year _____

NO→ Please complete risk assessment questionnaire also Mastectomy _____ Year _____

Radiation _____ Year _____

Prior Benign Breast Surgery or Procedure

Needle Core Biopsy **Right** **Left** Year _____ Facility: _____

Surgical Biopsy **Right** **Left** Year _____ Facility: _____

NONE or Cyst Drained **Right** **Left** Year _____ Facility: _____

Reduction **Right** **Left** Year _____ Facility: _____

Implants **Right** **Left** Year _____ Facility: _____

Do you have a history of Hodgkin's Disease treated with chest radiation therapy? **NO** **YES**

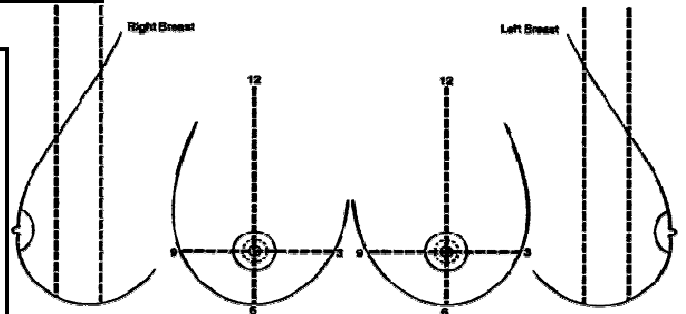
PATIENT'S SIGNATURE: _____ **DATE:** _____

Thank you for the information you have provided. You will receive a letter from us in about 2 weeks with information concerning the results of today's exam. If you have any questions, please ask the technologist performing your exam.

Technologist's Use Only

Lifetime risk _____ %
Lifetime population risk _____ %
Probability BRCA 1 _____ %
Probability BRCA 2 _____ %

Density used for Calculation (circle):
a b c d





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**MAMMOGRAPHY
Preliminary Results Notification**

This Option allows you to be called with the results of your exam within 24 hours of the day the exam is performed. There is no fee associated with this notification.

Please note: a letter will be mailed to you with your results whether or not you choose this notification option.

Your Signature on this document signifies your agreement to participate in **or** to decline the Preliminary Results Notification option.

I **DO** want to participate in the Preliminary Results Notification option.

I **DO NOT** want to participate in the Preliminary Results Notification option.

Signature

Printed Name

Date

If you would like this notification option, please provide contact information

Phone: _____

I agree to allow CRA Medical Imaging to leave my results

[] on my answering machine

[] with the individual who answers the phone

Comparison of previous studies is essential for accurate interpretation of your exam. CRA Medical Imaging may postpone delivery of preliminary results if previous mammography studies are not available for appropriate comparison by the radiologist.

For CRA Employee Use Only

Results Communicated to Patient: Date _____ Time _____

OR

Patient Unavailable, Left Message With: _____

Employee Initials _____