CRA MEDICAL IMAGING

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 a healthcare provider

1. Most Recent Breast Imaging: complete below or **NONE**

Mammogram: Date: _____ Facility: _____

Ultrasound: Date: _____ Facility: _____

MRI: Date: _____ Facility: _____

2. SINCE YOUR LAST MAMMOGRAM- are you CURRENTLY experiencing any **NEW** symptoms? ☐ **NO**

Lump	**Right**	**Left**
Tenderness-Not related to menstrual cycle	**Right**	**Left**
Nipple Discharge	**Right**	**Left**

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

3. Have you ever had an invasive breast procedure? If yes, please check all that apply: ☐ **NO**

Needle Core Biopsy	**Right**	**Left**	Year _____	Facility: _____ Results_____
Surgical Biopsy	**Right**	**Left**	Year _____	Facility: _____ Results_____
Cyst Drained	**Right**	**Left**	Year _____	Facility: _____
Reduction	**Right**	**Left**	Year _____	Facility: _____
Implants	**Right**	**Left**	Year _____	Facility: _____

4. Have you ever been diagnosed with Breast Cancer (including DCIS)? Please circle

NO→ Please complete risk assessment questionnaire also

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

Mastectomy _____ Year _____

Radiation _____ Year _____

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

6. COVID vaccine: N/A *or* Date of last dose_____ ☐ Right side ☐ Left side

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

Your signature indicates the information is accurate and answered to the best of your ability

Technologist's Use Only

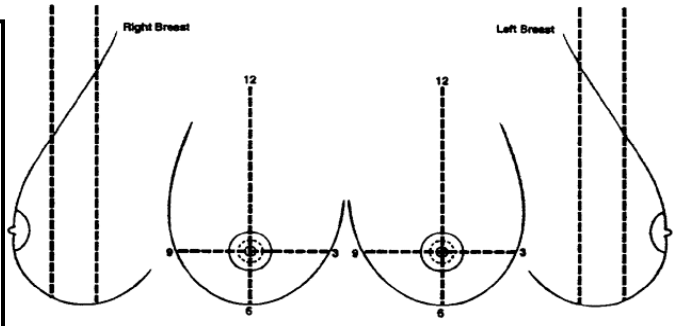
Lifetime risk _____%

Lifetime population risk _____%

Probability BRCA 1 _____%

Probability BRCA 2 _____%

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



11/09/2021

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MAMMOGRAPHY

Preliminary Results Notification

This Option allows you to be called with the results of your exam within 3 business days 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 _____