

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. Are you CURRENTLY experiencing any symptoms: No Yes

If yes, please specify: _____

Are these symptoms **NEW:** No Yes

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 _____%

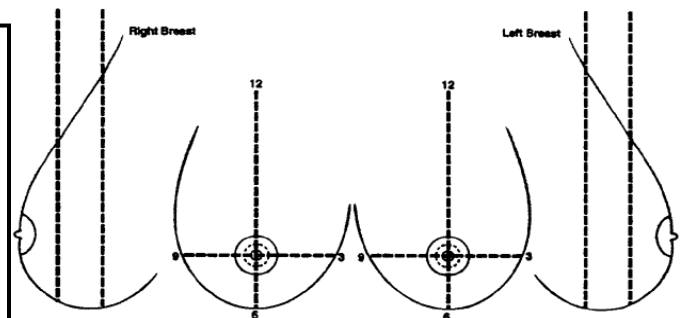
Lifetime population risk _____%

Probability BRCA 1 _____%

Probability BRCA 2 _____%

Density used for Calculation (circle):

a	b	c	d
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MAMMOGRAPHY **Preliminary Results Notification**

If you participate in the preliminary results notification, we will call you with your mammogram results once the radiologist completes the report. Please allow for up to four weeks for results.

Please note: a letter will be mailed to you with your results whether 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 _____