



Patient's Name: _____

Date of Birth: _____

Email Address: _____

By providing your email address, you consent to receive occasional emails from Pinehurst Radiology regarding products and services. Cell Phone is in the event we need to contact you.

Cell Phone: _____

Please fill in the information by circling the correct answer:

1. Are you presently taking hormones or oral contraceptives?	NO	YES	
2. Do you still have a menstrual cycle?	NO	YES	If no: Age of Hysterectomy/Menopause
3. Do you have a personal (yourself) history of breast cancer?	NO	YES	RIGHT LEFT
4. Do you have a family history of breast cancer?	NO	YES	
	If yes, Mother Sister Daughter		Age of diagnosis:
5. Have you ever had surgery or a biopsy on your breast?	NO	YES	RIGHT LEFT
o If Benign (not cancer):	Needle Biopsy Surgical Biopsy		When:
o If Cancer:	Lumpectomy Mastectomy Radiation Therapy		When:
o If Implants:	Silicone	Saline	When:
o If Breast Reduction:	When:		
6. Are you having problems with your breast?	NO	YES	How long?
o Lump:	RIGHT	LEFT	BOTH
o Discharge:	RIGHT	LEFT	BOTH
o Other:	RIGHT	LEFT	BOTH
			Color: Specify:
7. Are you pregnant or nursing?	NO	YES	
8. Have you had a previous mammogram?	NO	YES	When:
	Where:		

Patient Signature _____

Date _____

Screening

Diagnostic

*****OFFICE USE ONLY*****

The "post biopsy mammogram for marker placement" lay summary was given to the patient.

_____ I was informed about the change in my Mammogram from Screening to Diagnostic

