

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Physician: \_\_\_\_\_ **When did your doctor perform your last clinical breast exam?** \_\_\_\_\_

**Is this your first mammogram?**  YES  NO If NO, when was your last mammogram? \_\_\_\_\_

Name & address of the clinic where you had your last mammogram: \_\_\_\_\_

→ To authorize transfer of your records, please complete the form on the back. →

**BREAST HEALTH:** If you are having any problems with your breasts, please mark the symptoms in this section:

Lump or Thickening RT LT BOTH Infection or Inflammation RT LT BOTH

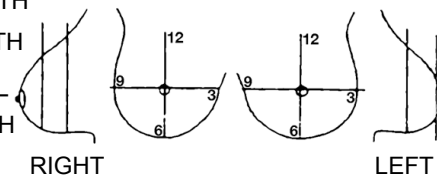
Pain or Tenderness RT LT BOTH Recent Breast Injury RT LT BOTH

Nipple Discharge RT LT BOTH Discharge Color \_\_\_\_\_

Nipple Abnormality RT LT BOTH Fibrocystic Change RT LT BOTH

Large Lymph Nodes RT LT BOTH Other \_\_\_\_\_

How long have you had these symptoms? \_\_\_\_\_



**BREAST CANCER:** Have you had breast cancer?  YES  NO

1. If YES, which breast? RT LT BOTH When were you diagnosed? \_\_\_\_\_

2. If YES, please mark which treatments you have had done:

Lumpectomy RT LT BOTH Mastectomy RT LT BOTH

Radiation RT LT BOTH Chemotherapy RT LT BOTH Tamoxifen or Evista?  YES  NO

Reconstruction RT LT BOTH Type of reconstruction: \_\_\_\_\_

**IMPLANTS:** Do you have implants?  YES  NO 1. If YES,  RT  LT  BOTH 2. Type:  Saline  Silicone  Don't know

**PROCEDURES:** Please mark any of the following procedures you have had done.

Breast MRI  RT  LT  BOTH Needle biopsy  RT  LT  BOTH Cyst aspiration  RT  LT  BOTH

Surgical biopsy  RT  LT  BOTH Breast reduction  RT  LT  BOTH None

**FAMILY HISTORY:** Has anyone in your family had breast cancer?  YES  NO If yes, please check below:

Mother \_\_\_\_\_  Sister \_\_\_\_\_  Daughter \_\_\_\_\_  Grandmother \_\_\_\_\_

Aunt \_\_\_\_\_  Niece \_\_\_\_\_  Female cousin \_\_\_\_\_

Father  Brother  Son  Grandfather  Uncle  Nephew  Male cousin

**OVARIAN CANCER:** 1. Have you had ovarian cancer?  YES  NO If YES, when were you diagnosed? \_\_\_\_\_

2. Has anyone in your family had ovarian cancer?  YES  NO If YES, specify: \_\_\_\_\_

**GYNECOLOGICAL HISTORY:** Please answer the following that apply to you.

1. **Are you pregnant?**  YES  NO  Don't know

2. If you are still having periods, when was your last one? \_\_\_\_\_

3. If not, have you gone through menopause?  YES  NO  Don't know If yes, age: \_\_\_\_\_

4. Have you had a hysterectomy?  YES  NO If yes, ovaries removed?  YES  NO Age: \_\_\_\_\_

5. Are you currently taking hormones or birth control pills?  YES  NO Name of hormone/birth control: \_\_\_\_\_

6. If no, have you ever taken them?  YES  NO When did you stop taking them? \_\_\_\_\_

7. How many times have you been pregnant? \_\_\_\_\_ How many live births have you had? \_\_\_\_\_

8. Your age when you delivered 1st live birth? \_\_\_\_\_ Age at last live birth? \_\_\_\_\_

I attest that the information I have provided on this form is true to the best of my knowledge

\_\_\_\_\_  
Signature of Patient or person authorized to consent for patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Tech Initials

**AUTHORIZATION FOR RELEASE  
OF PRIVATE HEALTH INFORMATION**

To: \_\_\_\_\_  
Name of radiology clinic or hospital where images were taken

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

I hereby request that my Private Health Information be released to:



**the  
breast  
center**  
A MANA Clinic

**55 W. SUNBRIDGE  
FAYETTEVILLE, AR 72703**

*Phone: 479-442-6266 Fax: 479-521-3877*

**PLEASE SEND THE LAST 2 YEARS OF BREAST IMAGING FILMS ALONG WITH ALL BREAST IMAGING REPORTS AND PATHOLOGY REPORTS YOU HAVE ON FILE.**

This Authorization shall be deemed to expire on the earlier of one (1) year from the date set forth next to my signature or within reasonable time following completion of the event which gave rise to the purpose of this Authorization.

I understand that I have the right to revoke this Authorization in writing at any time and that I may do so by delivering a revocation in writing to the Clinic.

I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the receiving entity and may no longer be protected by the Privacy Standards of this Clinic.

The Clinic has informed me that the Clinic will not condition treatment, payment, enrollment, or eligibility for benefits on obtaining this authorization.

I understand that I may refuse to sign this Authorization.

**Patient name (print):** \_\_\_\_\_ **D.O.B.:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

In the event the Authorization is being executed by a personal representative, guardian, or parent, please print your name and relationship to the patient. \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_