6716 NW 11th Place
Gainesville, FL 32605-4215
Telephone (352) 331-9729
Fax (352) 331-8692
www.doctorsimaginggroup.com

Today's Date: ______________________
Patient Name: _____________________ Patient Number: ___________________
Date of Birth: ______________________ Age: ________________
Ethnicity: _________________________

MAMMOGRAPHY LIFETIME ASSESSMENT QUESTIONNAIRE:

Do you have a history of Breast Cancer or Ductal Carcinoma in Situ (DCIS) or Lobular Carcinoma in Situ (LCIS) or received any radiation therapy to the chest for treatment of Hodgkin Lymphoma? YES NO UNKNOWN

Do you have a mutation in either BRCA1 or BRCA2 gene or a diagnosis of genetic syndrome that may be associated with risk of Breast Cancer? YES NO UNKNOWN

What is your Age? _______ What is your race/ethnicity? ________________ What is the sub race/ethnicity or place of birth: ________________________

Have you ever had a Breast Biopsy with a **BENIGN (not cancer)** diagnosis? YES NO N/A
a. How many **BENIGN (not cancer)** breast biopsies have you had? __________
b. Have you had a Breast Biopsy with "**Atypical Hyperplasia**" as the diagnosis? YES NO N/A

What age was your first menstrual period? _______ What age was your First Full Term Pregnancy? _________
How many of your "first-degree" relatives (mother, sister, daughter) have had Breast Cancer? __________

CURRENT BREAST CONCERNS

NEW lumps	NO	YES	RIGHT	LEFT	How long? ______________________________
NEW pain	NO	YES	RIGHT	LEFT	How long? ______________________________
NEW nipple discharge	NO	YES	RIGHT	LEFT	How long? __________ Color?_______________
NEW skin thickening	NO	YES	RIGHT	LEFT	Describe: _______________________________

SURGICAL PROCEDURES AND HISTORY

History of Breast Cancer	NO	YES	RIGHT	LEFT	Date: ___________ Type:____________
Mastectomy	NO	YES	RIGHT	LEFT	Date: ____________________________
Lumpectomy/ Partial Mastectomy	NO	YES	RIGHT	LEFT	Date: ____________________________
Radiation or Chemotherapy	NO	YES	RIGHT	LEFT	Date: ____________________________
BREAST Biopsy or Surgery	NO	YES	RIGHT	LEFT	Date: _______ Results: Cancer/No Cancer
Breast Implants	NO	YES	RIGHT	LEFT	Date: ___________ Type:____________
Breast Reduction/Lift	NO	YES	RIGHT	LEFT	Date: ____________________________
Have you had a mammogram before?	NO	YES	If yes, what facility?_____________		When?______________
Are you Possibly Pregnant?	NO	YES			

Patient Signature: ____________________________________ **Date:**_________________

TECHNOLOGIST USE ONLY

Type of exam being performed today: **ROUTINE BASELINE DIAGNOSTIC R/L/B QUICKSCREEN**

Mass or Lump	R	L	NEW	CHRONIC	
Pain	R	L	NEW	CHRONIC	Site: ___________
Nipple Inversion/Discharge	R	L	NEW	CHRONIC	

Outside Prior Films Requested? N Y Most Recent Date: ______________
Comments: ____

Radiologist: ______________
Technologist: _____________
Room: ___________

Digital Screening Mammograms

Patient Name: ________________ DOB: ________________ Patient Number: _________________

Occasionally, additional exams are required for complete diagnosis. If a **Diagnostic Mammogram** and/or **Breast Ultrasound** are required in addition to a normal **Screening Mammogram**, I understand that any additional exams will be added to today's appointment. The payment of patient's responsibility for additional exams is typically expected at time of service.

Patient Signature: ______________________________ Date: ____________________

Medicare Limitation of Liability

Medicare will only pay for services it determines to be "reasonable and necessary" under Section 1862(A)(1) of the Medicare law. If Medicare determines that a particular service is NOT "reasonable and necessary" under Medicare program standards, Medicare may deny payment.

Who's eligible?

- Women with Part B between ages 35-39 can get one baseline mammogram.
- Women with Part B, age 40 or older, are covered once every 12 months (11 full months must have passed since the last screening mammogram).