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**CHRISTOPHER L. PETTI, MD**  
ACCREDITED BY THE AMERICAN COLLEGE OF RADIOLOGY

Account #: _____	Today's Date: _____
Name: Last _____ First _____	
Date of Birth: _____	Age: _____

Send the report to the following physician(s): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you pregnant?  Yes  No Date of your last menstrual period: \_\_\_\_\_

Have you breastfed in the last three months?  Yes  No

**Are you currently on Hormone Replacement Therapy?**  Yes  No

**Do you have any new significant medical conditions?**  No

Yes – please explain: \_\_\_\_\_

**What is the reason for your visit?**

This is a routine exam. I DO NOT CURRENTLY HAVE ANY BREAST PROBLEMS.

I have the following problem: \_\_\_\_\_

**Since your last visit, have you had a breast biopsy or any surgical procedures?**  No

Yes – please explain: \_\_\_\_\_

**Since your last visit, has anyone in your family received a breast cancer diagnosis?**  No

Yes – please identify their relationship to you and age: \_\_\_\_\_

**Since your last visit, have you or anyone in your family been tested for BRCA or any other breast cancer genetic mutations?**  No  Yes – please identify yourself or relationship to you and results of the test:  
\_\_\_\_\_

I verify that the answers I have provided to the questions on this form are correct and understand that withholding information or inaccurate information may adversely affect the interpretation of this exam.

Patient's signature: \_\_\_\_\_

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

**NOTE: If you have previous films and/or reports with you, please give them to the receptionist before your exam.**