



**EXISTING
PATIENT
BREAST IMAGING
REGISTRATION
FORM**

TECHNICIAN INITIALS
M: TB KS SS MS LM
U: GS JD DD

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 discs and/or reports with you, please give them to the receptionist before your exam.