



EXISTING
PATIENT
BREAST IMAGING
REGISTRATION
FORM

TECHNICIAN INITIALS

M: ☐ TB ☐ KS ☐ SS ☐ MS ☐ LM

US: ☐ JD ☐ RC ☐ NB ☐ IB

Account #: _____

Today's Date: _____

Name: Last _____

First: _____

Date of Birth: _____

Age: _____

Send the report to the following physician(s):

Are you pregnant? ☐ Yes ☐ No

First day 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 upon check-in.