



**EXISTING  
PATIENT  
BREAST IMAGING  
REGISTRATION  
FORM**

TECHNICIAN INITIALS  
M:  TB  KS  LM  CV  
US:  JD  RC  DB

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:  
\_\_\_\_\_

Are you allergic to **LATEX**?  Yes  No

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.**