EAGLES LANDING FAMILY PRACTICE
Providing care at your convenience

Mammography Patient Questionnaire

Office Use Only:
Ins Ref #_____

Patient Name: _____ DOB: _____ Date: _____
Address:_____ City: _____ State: _____ Zip:_____
Home Phone: _____ Cell Phone: _____ Referring Physician: _____

Previous Mammograms

Is this your first mammogram? □ Yes □ No

If no, when and where did you have your most recent mammogram? _____
_____

Reason

□ New Problem: Please Describe _____

□ Routine/Annual □ Short term follow up _____

Family History of Breast Cancer

Has any blood relative had breast cancer? If so, please indicate each relative and their relationship to you:

Relationship: _____ Age at diagnosis:_____ □ Maternal □ Paternal Relationship: _____ Age at diagnosis:_____ □ Maternal □ Paternal

Relationship: _____ Age at diagnosis:_____ □ Maternal □ Paternal Relationship: _____ Age at diagnosis:_____ □ Maternal □ Paternal

Other:

Medical History

Are you pregnant? □ Yes □ No
How many full term pregnancies have you had? _____
Was your first pregnancy before the age of 35? □ Yes □ No
Did you breastfeed? □ Yes □ No
Date of last period: _____ Age at first period: _____
Age at hysterectomy: _____ Age at menopause: _____

Hormone Use? □ Yes □ No
Type:_____
Currently Using? □ Yes □ No
How long have you used? _____

Oral Contraceptive Use? □ Yes □ No
Age at first use? _____
How long have you used? _____

Personal History

Please indicate date and side of each of the following ***(please mark N/A if not applicable)***:

	Side			Date		Side			Date
□ Benign Surgical Biopsy/Excisional	L	R	N/A		□ Mastectomy	L	R	N/A	
□ Cyst Aspiration	L	R	N/A		□ Chemotherapy	L	R	N/A	
□ Breast Reduction	L	R	N/A		□ Radiation	L	R	N/A	
□ Lumpectomy	L	R	N/A		□ Breast Implants	L	R	N/A	

DIAGRAM BELOW FOR TECHNOLOGIST ONLY
Patient ID: _____ Tomosynthesis? □ Yes □ No

Right **Left**

Technologist Notes: _____
_____
_____
_____
_____
_____
_____

_____ _____
Technologist Date

□ Disinfectant of Compression Devices

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MAMMOGRAM INFORMED CONSENT

Please read each paragraph carefully and sign and date the form.

- I understand that a mammogram is only 90% accurate in detecting breast cancer and is only a partial examination for diagnosing breast cancers.
- I understand, based on my clinical symptoms, I may be referred for additional mammogram films, an ultrasound or to a surgeon.
- I understand that I am responsible for getting my results if I have not heard from my physician after 2 weeks.
- I understand periodic breast examinations should be done by a physician.
- I understand if after seeing my physician I continue to have breast problems, regardless of a negative report on the mammogram, I will contact my physician for instructions on further follow up.
- I understand some redness and/or tenderness of my breasts may occur following the mammogram due to the compression device necessary for good images, but these symptoms should be gone within 24 – 48 hours.
- I understand a mammogram does require the use of low dose radiation; therefore, I will inform the technologist if I think I might be pregnant.

_____ _____/_____/_____
Patient's Signature Date

_____
Patient's Name (Please Print)

_____ _____/_____/_____
Witness Date

Imaging Center
1100 Hospital Drive, Stockbridge, GA 30281
Phone: 678-432-6161 Fax: 678-432-3677

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AUTHORIZATION FOR RELEASE OF MAMMOGRAM FILMS

Date: _____/_____/_____

Facility of Previous Mammogram Films:

Facility Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

I hereby authorize the practitioner of the facility listed above to release my **mammogram/breast ultrasound films** to the Imaging Center of Eagles Landing Family Practice.

Please forward films or CD's and reports to:

Eagles Landing Family Practice
Imaging Center
1100 Hospital Drive
Stockbridge, GA 30281

678-432-6161 Fax 678-432-3677

Patient Name: _____ Date of Birth: _____/_____/_____

Signature of Patient: _____ Date: _____/_____/_____

Witness: _____ Date: _____/_____/_____

Office Use Only:

Please advise whether or not previous images are available

_____ *Yes, we do have images and will send.*

_____ *No, we do not have patient/images on file.*

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3D Mammogram Upgrade

3D Mammography is a new screening and diagnostic tool designed for early breast cancer detection.

During the 3D portion of the exam, the X-ray arm sweeps in a slight arc over your breast, taking multiple images. This provides greater detail, allowing the radiologist to examine your breast tissue in one millimeter slices. They can scroll through images of your entire breast like pages of a book.

The additional 3D images make it possible for a radiologist to gain a better understanding of your breast tissue and possibly reduce the need for follow-up imaging.

3D mammography complements standard 2D mammography and is performed the same way as the 2D system. Compression is still required and takes a few more seconds.

The 3D Mammogram may not be covered by insurance but we will submit the claim to your insurance company. If it is not covered, you will be billed the cost of the 3D mammogram at a later date. The cost of this procedure is $60.00.

☐ **Yes**, I would like the 3D Imaging. I acknowledge that the 3D mammogram may not be covered by my insurance company and that the fee associated will be my responsibility.

☐ **No**, I choose not to have the 3D Imaging. I acknowledge I will have 2D Imaging.

_____ _____

Signature Date

_____

Print Name

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