EAGLES LANDING HEALTH
Providing care at your convenience.

APPOINTMENT TIME: ____________
ORDERING PROVIDER: ____________
PATIENT ACCT#: ______________

Mammography Patient Questionnaire

Patient Name:_________________________________ **DOB:** ____________ **Age:**______
Height:____________ **Weight:** ___________ **Best Phone:**_______________/_____________

3D Tomosynthesis Technology? Yes______ No ________ Signature ____________________

Previous Mammograms: Is this your first mammogram? Yes_____ No ________
If no, when was your last Mammogram? _____________ Where? __________________________
Is this a **follow-up** mammogram? Yes: ________No: ________ **Routine**? Yes: ______No: _______

Current Medical History:
Do you have any **new** breast problems today? Yes: ______No: ________
If "yes", describe: ____ Since when: ________________
Did you or your doctor feel a lump in your breasts? Yes: _____No: ___ Since when: ___________
Left Breast? _______ Right Breast? ______Both? _______ For how long has it been there? ______
Personal history of **Breast Cancer**? Yes ___No___ LT___ RT___ Age at diagnosis __________

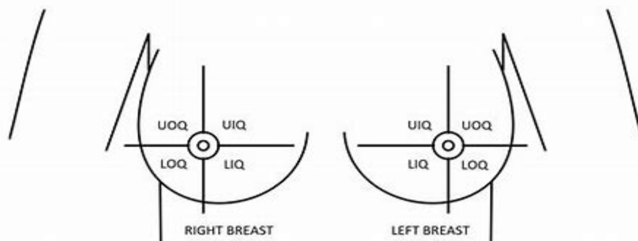
Previous Breast Surgery:

				Date:					Date:
Benign Biopsy	L	R	N/A		Breast implants	L	R	N/A	
Excisional BX	L	R	N/A		Mastectomy	L	R	N/A	
Cyst Aspiration	L	R	N/A		Partial Mastectomy	L	R	N/A	
Reduction	L	R	N/A		Radiation Therapy	L	R	N/A	
Lumpectomy	L	R	N/A		Chemotherapy	L	R	N/A	

Menstrual Cycle History: History of **Ovarian Cancer**? Yes: ______No: _____ If yes, at what age? ____
Age at your first menstrual cycle ______ Are you still having periods? Yes: _____ No: ______
Are you pregnant or nursing? Yes: _____No: ____ LMP ________ Age at first childbirth ______
Age at **last** cycle _______ Are you post-Menopausal? ________ Hysterectomy? Age _________
Are you taking hormonal therapy? Yes: _____No: ____ If "yes", what type ____________________
Age started hormonal therapy ______ Total number of years _________

Family History: Has any blood relative had **Breast cancer**? Yes: ______No: _____ If yes, Mother age ___
Sister - age______ Paternal Grand-age ______ Maternal Grand-age _______ Paternal aunts-age ______
Maternal Aunt-age ____ Daughter-age _____
Has any blood relative had **Ovarian cancer?** Yes: ______No: _____ If yes, Mother age______, Sister-age___
Paternal Grand-age ____Maternal Grand-age ____ Paternal aunt(s)-ages _____/___ Maternal
Aunt(s)____ Daughter-age _____ Have you ever had Genetic Testing? Yes: ______No: _____Results: _____

Office Use Only



Technologist notes:

____

Tech Signature: _________________________Disinfectant of Compression Devises: ______ Date_________

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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

Consent for Mammogram with Implants

Patient Name: ___________________________________ D.O.B. ___________________

The following has been explained to me in general terms and I understand that:

1. The diagnosis requiring this procedure is to:
   Perform quality Mammography

2. The nature of this procedure is to:
   Perform Mammography with implants

   The compression device should literally pull a maximum amount of breast tissue away from the chest wall where the implant is placed onto the image receptor, and immobilize the tissue adjacent to the implant and/or chest wall for all views. Good compression maximizes the amount of breast tissue imaged, immobilizes the breast, reduces the amount of scattered radiation, and facilitates the distinction between less dense benign structures and denser malignant lesions. Vigorous compression enables precise evaluation of fine calcification for better image quality.

3. The purpose of this procedure is to:
   Perform a good image quality low dose mammogram exam on those patients with any form of implant prosthesis.

4. Material risks of this procedure are:
   As a result of this procedure there may be material risks of slight breast tenderness due to adequate vigorous compression. There is a slight risk of implant rupture.

5. Practical alternatives to this procedure include: N/A

6. It is our judgment that refusal to consent to the performance of this diagnostic procedure will not necessarily influence prognosis other than to possibly withhold diagnostic information from the referring physician.

Patient Signature: ___________________________________ Date: ______________________

I understand that the physician, medical personnel, and other assistants will rely on statements about the patient, the patient's medical history and other information to determine whether or not to perform the procedure, to determine the course of treatment for the patient and in order to recommend the procedure, which has been explained to the patient.

AUTHORIZATION FOR RELEASE
OF MAMMOGRAM/ULTRASOUND IMAGES

Date: ________/________/__________

Facility of Previous Mammogram Films:

Facility Name: ____

Street Address: ____

City: ____________________________ State: ________ Zip: _______________

Phone: ___________________________ Fax: ____________________________

Last name at time of previous mammogram: ______________________________

*Please note, your exam will be held for 14 days prior to being read by the radiologists. ELH will make all attempts to acquire previous mammogram films for comparison.

I hereby authorize the practitioner of the facility listed above to release my **mammogram/breast ultrasound films/Pathology results** to

Eagles Landing Health
Imaging Center
1100 Hospital Drive
Stockbridge, GA 30281

Ph. 678-432-6161 Ext. 13144 **Fax** 678-432-3677

This authorization is valid from the date of my or my representative's signature below and shall expire in 366 days unless otherwise noted by me or my representative.

Patient Name: ___________________________________ Date of Birth: _______/_______/________

Signature of Patient: ______________________________________ Date: _______/_______/________

Name of Rep: _________________________Signature __________________________ Date: __________

Releasing Facility: please fax this form to Eagles Landing Health, Imaging Center.

Images PowerShared on:________________ Films/Images on CD/DVD Mailed on: ______________ No record in our system - Initial ________

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

Imaging Center

1100 Hospital Drive, Stockbridge, GA 30281

Phone: 678-432-6161 Fax: 678-432-3677