

The ImageCare Centers
Male Mammography History

See Back>>>>>

Date: / /

3D (Tomosynthesis)? Y N (If YES, complete ABN)

To be filled out by patient

Note: If there is deodorant or powder on your breast or underarms, please remove it before your mammogram. Ask technologist for help if needed.

Name: _____ Birth date: / / Age:

Home phone: / -_____ Alternate phone: / -_____

Referring MD: _____ Primary Care Doctor: _____

Have you ever had: Mammogram Ultrasound or MRI of the breast

If yes, where and when: _____

Reason for mammogram: _____

History of breast cancer in your family? Yes No

If yes who? Self Mother Sister Other _____ What age?:

Do you or have you used hormones? Yes No

Which type? _____ How long? _____ Still using?

It is not unusual for some patients to be called back for additional views and/or an ultrasound to complete the study. Your results will be mailed to your physician and yourself within 7-10 days. If you have any questions about this questionnaire or the exam, please ask the technologist.

*****TO BE FILLED OUT BY THE TECHNOLOGIST*****

Check: Breast surface (medial and inferior)

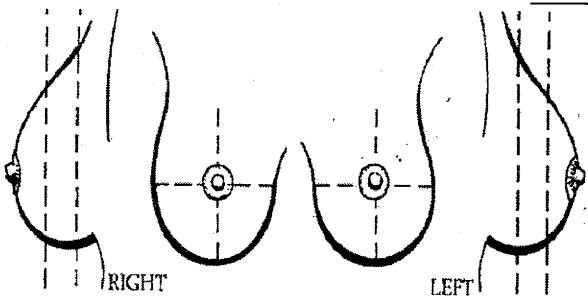
Palpable mass, scars, moles, warts, tattoos etc.

Nipples: Inverted? Y N Is there Discharge? Y N For how long? _____

Breast size discrepancy? Y N Which? _____

Previous breast surgery, aspiration or radiation? Y N

If yes when? _____ Benign? Y N Comments: _____



% Incision
. Granular
O Lump
/// Ropiness
X Tenderness

Tech Initials _____ X-Ray # _____

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I understand that if I need my mammography and/or ultrasound images to bring to a specialist, or other facility, I need to provide a minimum of 24 hours prior to arriving to pick them up.

Patient Signature _____