FACILITY:_____

RADNET MANAGEMENT, INC.
A premier network of centers providing diagnostic radiology and imaging services.™

History Form

FORM.POL.002
Effective Date: June 1, 2009

BREAST HISTORY

Name: _____ Age:_____ Date:_____

Doctor: _____

Reason for this examination: _____

Have you ever had a Mammogram / US before? Yes No When? _____ Where?_____

Have you ever had a Breast MRI before? Yes No When? _____ Where?_____

1. **PHYSICAL CONCERNS**			**Right**	**Left**	**How Long?**
Do you feel a lump?	Yes	No			
Is this a new finding?	Yes	No			
Focal or specific point of pain?	Yes	No			
Have you had recent trauma to breast?	Yes	No			
Nipple discharge or retraction?	Yes	No			
Skin dimpling?	Yes	No			

Additional Information:_____

2. B**REAST SURGICAL HISTORY:**			**Right**	**Left**	**Month / Year**
Previous breast cancer	Yes	No			/
Mastectomy	Yes	No			/
Lumpectomy (cancer)	Yes	No			/
Radiation therapy	Yes	No			/
Chemo	Yes	No			/
Biopsies (Needle or Surgical)	Yes	No			/
Needle aspiration	Yes	No			/
Reconstruction/Reduction	Yes	No			/
Implants or silicone injections	Yes	No			/

Additional Information:_____

3. **GENERAL HISTORY**:

Are you pregnant?	Yes	No
Breast fed within last 4-6 months	Yes	No
Any family history of breast cancer?	Yes	No
Which relative Age?_____	Yes	No
Have you had any other type of cancer?	Yes	No

If yes, what kind?_____

How old were you when you had your first full term pregnancy:_____Yrs.

4. **MENSTRUAL PERIODS**

Menopause?	Yes	No
Hysterectomy?	Yes	No

Are you taking any hormone/birth control pills?

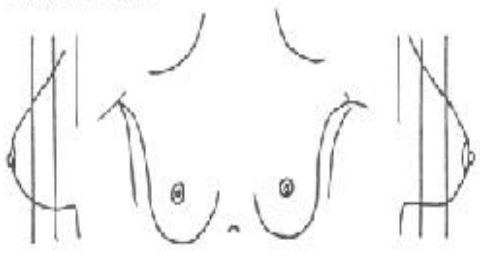
What kind?_____

How long? _____

Additional Information:_____

OFFICE USE ONLY

Clinical Findings



Clinical indications/Notes:

_____

_____

_____

_____

Technologist's name:_____

1. On review of your screening mammogram, if an area needs further evaluation, we will contact you to schedule an appointment. (There is an additional charge for these views).
2. If an ultrasound examination is recommended, this is considered a separate study and separate charge.
3. To the best of my knowledge, all of the above is true and correct.

Patient: _____ **Date:** _____/_____/_____
(Signature)