

Patient Please Complete
ALL QUESTIONS MUST BE ANSWERED

Previous Mammography Information

Yes No 1. Have you had a mammogram before?
Date of previous mammogram _____
Facility name where mammogram was taken: MJH Other: _____

No Yes Were you registered under the same name?
If No, what was your name? _____ Facility address _____
_____ City State Zip

No Yes 2. Is this mammogram routine? If no, why _____

(lump, discharge, retraction, thickness, pain, following of calcification, following of density).

Menstrual History

3. Menstrual Status: Pre Menopausal Post Menopausal
Age at last menstrual cycle _____

Yes No Are you currently pregnant?
Date of last menstruation _____ Age at first menstrual cycle _____ # pregnancies _____

No Yes Have you ever breast fed?
 No Yes 4. Have you had a child? # live births _____ Age at first live Birth _____

Family History

Yes No 5. Is there a history of breast cancer in your family?
If yes, at what age was it found? My self _____ Age Mother _____ Age Sister _____ Age
 Daughter _____ Age Other _____ Age

Patient Breast Cancer/Breast Surgery

Yes No 6. Do you, or have you, used hormones? (Estrogen, premarin, provera, tamoxifen) Date started _____
Which type? _____ How long? _____ Still using? _____

Yes No 7. Have you breast fed within the last 3 months?

Yes No 8. Have you had a weight change of more than 10 pounds since your last mammogram?
Gain/Loss (circle one) _____ lbs.

Yes No 9. Have you had trauma to your breast that caused black and blue marks? When? _____

Yes No 10. Have you had breast surgery? If, yes why? _____ When? _____
 Benign Malignant

Yes No 11. Have you had a biopsy? If, yes why? _____ When? _____
 Benign Malignant
Prior cancer type _____ Date _____

Yes No 12. Previous radiation?

Yes No 13. Previous chemotherapy?

Yes No 14. Do you have breast implants?

Yes No 15. Previous breast problems? _____

Patient's Signature

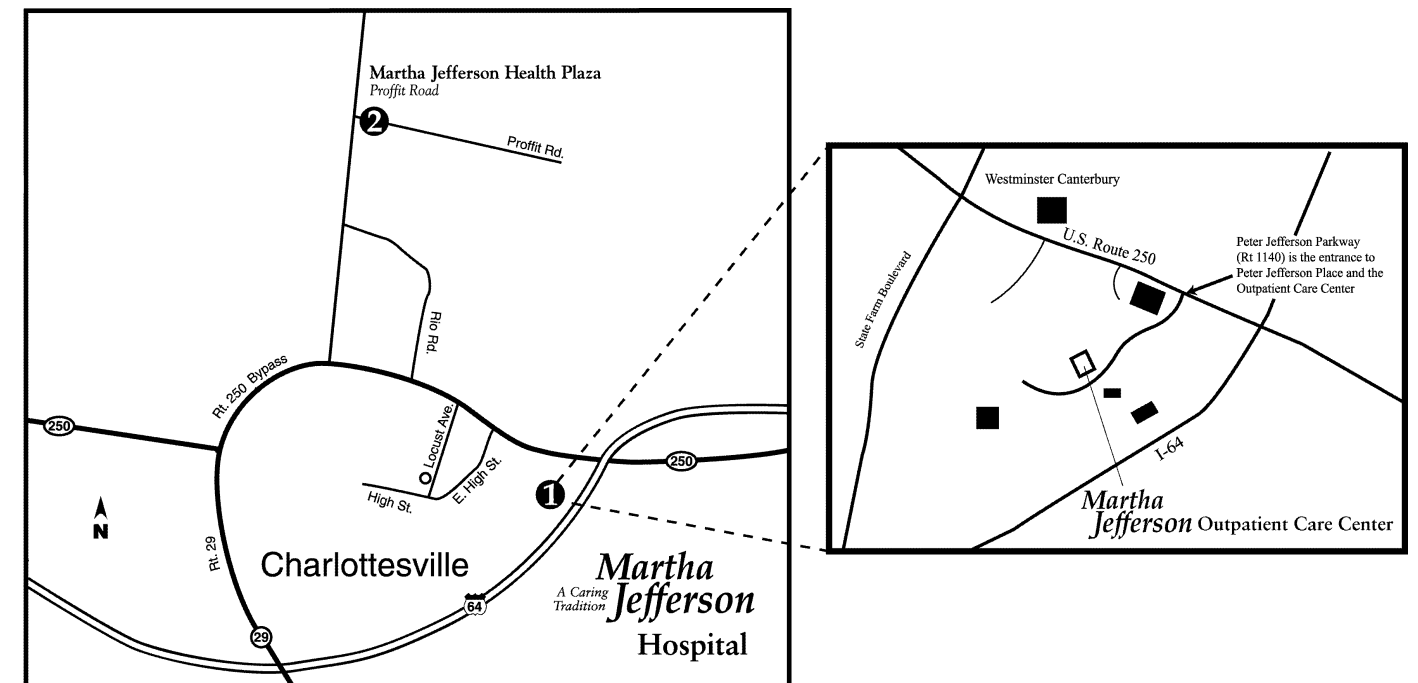
Martha
Jefferson Women's Health Center

Toll Free (866) 866-8757 • Outpatient Care Center Mammography (434) 244-4480

Mammography Consultation Request

Patient Instruction On The Day of Your Test

1. Please Bring This Form With You To Your Appointment
2. Please Do Not Wear Deodorants, Powders Or Creams The Day Of This Test
3. If Your Appointment Is At The Outpatient Care Center, Go Directly To The 3rd Floor, Suite 380.
4. Arrive 10 Minutes Early for Registration
5. It is possible that you may need to return for special views or an ultrasound. These are needed to further evaluate something that has been seen on the screening mammogram. These views usually suffice and no further evaluation is necessary. However, occasionally a biopsy will be advised.
6. Once the films are interpreted by the Radiologist, a letter will be sent to you with the results of your mammogram.
7. The charge for the mammogram interpretation will be billed separately, by Charlottesville Radiology, Ltd.
8. If you have any questions or concerns regarding your exam please call (434) 244-4480 and ask for the mammography supervisor.
9. If you are handicapped, please schedule your appointment for the Outpatient Care Center to reduce your chances of being called back for additional views.



1. Outpatient Care Center (595 Peter Jefferson Parkway) (Screening and Diagnostic Mammograms.)
2. Martha Jefferson Health Services (3263 Proffit Rd)(Screening Mammogram Only)

MJH031

Important Notes About Your "Screening Mammogram"

A screening mammogram consists of two X-ray images of each breast. It's purpose is to detect cancers in the very early stages when they are too small to be felt by a doctor. A screening mammogram finds such cancers about 80 percent of the time. As effective as it is, a mammogram alone is not a complete screening. The physical examination by your doctor is a very important part of maintaining your health, as some cancers can be felt but do not show up on a mammogram.

It is possible that you may need to return for special mammogram views and/or a breast ultrasound. Many times this "callback" is because there is an area of breast that needs additional evaluation in order to ensure that there are no persistent suspicious abnormalities. Most commonly, these views usually suffice and no further workup is necessary. However, occasionally a biopsy will be advised.

If a biopsy is recommended by your doctor, our Women's Health Liaison is available to help you understand and prepare for a biopsy procedure. Her telephone number is (434) 244-4483.

Thank you for entrusting your care to Martha Jefferson Hospital.

Please Print:

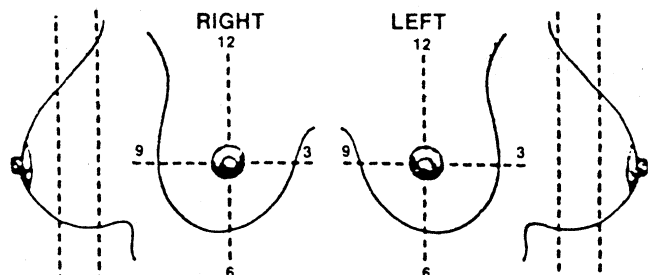
Name	DOB	Appt. Date	Appt. Time
Daytime Telephone	Social Security #		

Physician Please Complete

Location: Forest Lakes (Proffit Rd - 29N) Outpatient Care Center (595 Peter Jefferson Parkway)

Type of Mammogram Requested:

<input type="checkbox"/> SCREENING ANALOG (Routine, ACS Recommendations) <input type="checkbox"/> SCREENING DIGITAL (Recommended for premenopausal or perimenopausal women and for women with dense breasts) <input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT <input type="checkbox"/> BILATERAL	<input type="checkbox"/> DIAGNOSTIC (All Digital) (Performed only at Outpatient Care Center) <input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT <input type="checkbox"/> BILATERAL <input type="checkbox"/> Ultrasound at discretion of radiologists Please list pertinent physical findings and indicate problem area(s) on BOTH views of diagram below.
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REQUIRED FOR ALL EXAMS:
 Date of last Clinical Breast Palpation _____

Requesting Physician Signature _____

Current Breast Symptoms: Mass Dimpling
 Bloody Nipple Discharge Pain None

Physical Findings _____

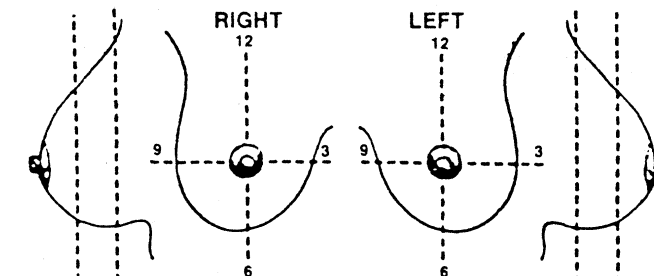
Technologist Please Complete

Mole

Lump

Scar

* Focal Pain



Yes No Pregnant? _____

Checked breast surface including medial and inframammary fold

Nipples: Inverted Discharge How long? _____ Which nipple? _____

Breast size discrepancy? _____

History of prior breast surgery (reason, place, date) _____

Reason for added view _____

Comments _____

Technologist Performing Mammogram