

NAME
DATE OF BIRTH

PLEASE ANSWER THE FOLLOWING:

Number of full term pregnancies?

Age at first pregnancy?

Age when menstruation began?

When was your last menstrual period?

Age at menopause?

PLEASE ANSWER THE FOLLOWING AS COMPLETELY AS POSSIBLE

	YES	NO	IF YES, PLEASE GIVE DETAILS
--	-----	----	-----------------------------

Are you currently pregnant?

Ever had ovarian cancer?

Family history of breast cancer?

 Who: Mother Grandmother

 Sister Aunt Daughter

Have you had a hysterectomy?

Have you had your ovaries removed?

Have you had a previous mammogram?

Have you ever had breast cancer?

Have you had any of the following since your

last mammogram: pain

nipple discharge

lumps

retraction

HAVE YOU HAD ANY OF THE FOLLOWING DONE TO YOUR BREAST? IF YES, WHICH SIDE AND WHEN

	YES	NO	RIGHT	LEFT	BOTH	WHEN
--	-----	----	-------	------	------	------

Implants

Needle biopsy

Excisional biopsy

Stereo biopsy

Breast reduction

Lumpectomy

Mastectomy

Radiation therapy

Chemotherapy

Injury

HAVE YOU EVER TAKEN ANY HORMONES?

	YES	NO	IF YES, PLEASE DESCRIBE
--	-----	----	-------------------------

Contraceptives

Estrogen

Progesterone

Tamoxifen

Other

PLEASE KEEP MY MEDICAL RECORDS AND FILMS HERE

INITIAL:

We're Seeing
New Ways
to Keep
You Healthy

100 Commons Way
Suite 110
Holmdel, NJ 07733
T: 732.671.6618
F: 732.671.7353
holmdelimaging.com

TECHNOLOGIST:

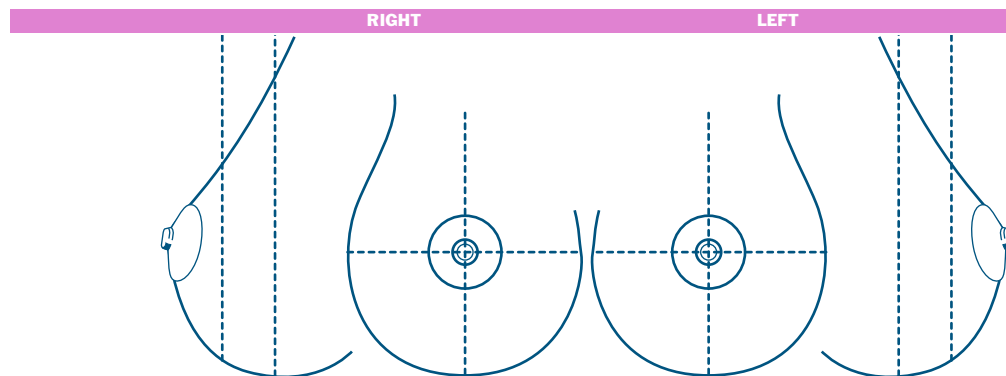
Notes:

REPEAT / REJECT ANALYSIS

Number of films:

Number of repeats:

Reason:



RADIOLOGIST:

RADIOLOGIST 2:

CAD:

IMPRESSION

	CHECK ONE
① Negative	<input type="checkbox"/>
② Benign	<input type="checkbox"/>
③ Probably benign	<input type="checkbox"/>
④ Biopsy	<input type="checkbox"/>
A Low	<input type="checkbox"/>
B Intermediate	<input type="checkbox"/>
C Moderate	<input type="checkbox"/>
⑤ Malignant	<input type="checkbox"/>
⑥ Known malignancy	<input type="checkbox"/>
⑦ Needs additional evaluation	<input type="checkbox"/>

Notes:

FOLLOW UP RECOMMENDATIONS

	CHECK ONE
NORMAL	
N Normal screening interval, follow ACS	<input type="checkbox"/>
N-1 Normal with 1 year follow up	<input type="checkbox"/>
N-6 Normal with 6 month follow up	<input type="checkbox"/>
INTERMEDIATE	
I-U Ultrasound	<input type="checkbox"/>
I-T Take action if highly suggestive of malignancy	<input type="checkbox"/>
I-Y Cytological analysis	<input type="checkbox"/>
I-P Additional projections	<input type="checkbox"/>
I-D Clinical assessment	<input type="checkbox"/>
I-S Spot Compression	<input type="checkbox"/>
I-M Magnification views	<input type="checkbox"/>
SHORT TERM	
F-OF Need outside films	<input type="checkbox"/>
F-6 6 month follow up	<input type="checkbox"/>
F-3 3 month follow up	<input type="checkbox"/>
F-U6 Us in 6 months	<input type="checkbox"/>
SURGICAL	
B Biopsy should be considered	<input type="checkbox"/>