



an MTT Corporation facility

1800 W Hibiscus Blvd., Suite 100 – Melbourne, FL 32901 - (321) 726-3800 – Fax (321) 726-3842

## Mammography Questionnaire

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ DATE: \_\_\_\_\_

- Have you ever had a mammogram?      \_\_\_ Yes      \_\_\_ No      \_\_\_ Don't Know
- Are you on hormone replacement therapy?      \_\_\_ Yes      \_\_\_ No      \_\_\_ Don't Know
- Have you had a breast reduction?      \_\_\_ Yes      \_\_\_ No      \_\_\_ Don't Know
- Do you have breast implants?      \_\_\_ Yes      \_\_\_ No      \_\_\_ Saline      \_\_\_ Silicone
- Have you ever had a breast biopsy?      \_\_\_ Yes      \_\_\_ No      \_\_\_ Right      \_\_\_ Left
- Have you ever been diagnosed with breast cancer?      \_\_\_ Yes      \_\_\_ No      \_\_\_ Right      \_\_\_ Left
- Have you ever had a mastectomy      \_\_\_ Yes      \_\_\_ No      \_\_\_ Right      \_\_\_ Left
- Do you have a family history of breast cancer?      \_\_\_ Yes      \_\_\_ No
- \_\_\_ Mother      \_\_\_ Sister      \_\_\_ Aunt      \_\_\_ Daughter      \_\_\_ Grandmother

### INFORMED CONSENT FOR BREAST IMPLANT MAMMOGRAPHY If not applicable, please circle: (N/A)

#### Description of Procedure:

Your physician, Dr. \_\_\_\_\_, has referred you to University Center Imaging for mammography of the breast(s). This form will explain the procedure and any possible complications that may result from said procedure.

There are specific modified views necessary for breast augmentation. These views require displacement of the prosthesis and compression of only the breast tissue. While this procedure greatly improves the visibility of the breast, infrequently there are complications, such as leakage or ruptures of the prosthesis. Such complications can occur even with the use of proper techniques and care taken during the procedure. However, with out this procedure it will be extremely difficult to determine the presence of micro calcification and or disease.

#### Consent:

I have been informed of the nature, risks and consequences of this procedure and that no guarantees have been made as to the results which might be obtained. I certify that I have read and fully understand the above information and that the explanations referred to are understood by me. I hereby consent to have the mammography procedure performed.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

**PREGNANCY INFORMATION**

If not applicable, please circle: (N/A)

Recognizing that there is a very small, but unknown risk to a developing fetus exposed to diagnostic levels of radiation, it is imperative that every effort is made to avoid unnecessary exposure to the fetus. For this reason, we require all females ages 12 to 55 to answer the following questions, before proceeding with your x-ray examination.

Patient's Name: \_\_\_\_\_

Females 12-55 years of age, please answer the following questions:

**I understand that radiation can be harmful to the unborn child.**

Date of last menstrual period: \_\_\_\_\_.

Please complete the following:

- I am pregnant.
- I may be pregnant.
- I am not pregnant.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Guardian, if under 18

\_\_\_\_\_  
Date