Mammography Specialists Medical Group

14651 S. Bascom Avenue, Suite 210, Los Gatos, CA 95032 * 18525 Sutter Blvd, Suite 260, Morgan Hill, CA 95037
(408) 356-6611 (T), (408) 356-9001 (F)
Website: Mammo.net

NEW PATIENTS COMPLETE LEFT SIDE, RETURNING PATIENTS MAKE CORRECTIONS.

Name _________________ Email _________________

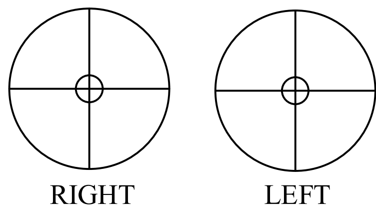
Preferred Language: _________________ Race: White | Hispanic | Asian | Other
Smoking History: _________________ Medications: _________________
Medication Allergies: _________________

MAMMOGRAM

Have you ever had a mammogram before? Please circle: Yes | No
If Yes, date _________________ Facility: _________________

Would you like the doctor to consult with you the results immediately after your study if the Doctor is available (must sign waiver) $115.00 **NOT** paid by insurance. Yes | No

Do you feel any breast lump, mass or thickening on your own physical exam today? Yes|No.
If yes, describe and show where on diagram.



Do you have nipple discharge? Yes | No If Yes, which side? Lt | Rt Color: ___
Do you have implants? Yes | No Lt | Rt
Are you pregnant or breastfeeding? Yes | No
Any hormone replacement therapy (HRT) how long ___________________

Have you personally had breast cancer? Yes | No
Have you personally had any other type of cancer? Yes | No What type? ________
Do you have a family history of breast cancer? Yes | No Unknown
If Yes, who?____ Age ________
Do you have any history of breast surgery? Yes | No
Mastectomy | Excisional Biopsy | Augmentation | Reduction | Core Biopsy

DEXA

Height: Ft. __ In. __ Weight: __
Are you Right handed? __ Left handed? __
Any Hip/Spine surgeries with metal or pins? Yes | No Location _________________
Have you had a barium study or injected with contract in the LAST 5 DAYS? Yes | No
Multivitamins? Yes | No

Alcohol - do you consume (on average) 2 or more drinks daily? Yes | No
Biological mother or father with history of a hip fracture? Yes | No
Use of steroids (3 or more months of prednisone or equivalent meds)? Yes | No
Previous history of adult fracture? Spontaneous? Trauma? Yes | No
Type 1 Diabetes, Premature Meno, Osteogenesis, Chronic Malabsorption Yes | No
Confirmed diagnosis of Rheumatoid Arthritis (RA)? Yes | No
Current Smoker Yes | No

- I understand breast ultrasound/diagnostic procedures apply to my deductible. Yes
- I acknowledge that a copy of HIPAA Notice is available at the reception desk. Yes
- I do not have Covid symptoms posted on the questionnaire. Yes

SIGNED _______________________________________ DATE _______________

PID#:

EXAM DATE

PATIENT DATA
Address:

Phone:
DOB:
Email:

INSURANCE PRIMARY
Primary Name:
Primary Policy:

Secondary Name:
Secondary Policy:

REFERRING DOCTOR (s)
Name:

Phone:

Fax:

Email:

FOR CLINICAL USE ONLY

Screening __ Lump __ Abnl __
Dx: Unilat __ Bilat __
Density: __% Tomo: ___

US: Left __ Right __ Bilateral
US 3D __ Limited __ Tractus __

Bx US___
Bx Stereo: LT __ RT __

Aspiration: LT __ RT __
Number done: __

Ductogram: LT __ RT __
w/ Injection: LT __ RT __

Jwire LT __ RT __ MMG __
Jwire LT __ RT __ US __

Dexa:
Screening __ Bone Abn __
Hips __ Wrist __
AP Spine __ w/ Lateral Spine __

2nd Opinion: __

Front __ Tech __ MD __ File __