Name:	Age:	GULFPORT OBSTETRICAL & GYNECOLOGICAL CLINIC, P. A.
MRN:	Sex:	
DOS:	DOB:	MAMMOGRAM HISTORY FORM

Why are you having this mammogram?

- ☐ Screening
- ☐ Lump or Thickening
- ☐ Skin Changes or Retraction
- ☐ Pain (Chronic or New)
- ☐ 3 or 6 Month Follow-Up
- ☐ Nipple Discharge (color of discharge _____)
- ☐ Breast Implant problem
- ☐ Other (please specify _____)

Have you ever had a mammogram? ☐ Yes ☐ No If yes, when? _____ Where? _____

Have you had any breast surgery or treatment? ☐ Yes ☐ No

Procedures:	Where:		When:	Results:
☐ Cyst Aspiration	Right	Left		
☐ Biopsies	Right	Left		
☐ Lumpectomy	Right	Left		
☐ Mastectomy	Right	Left		
☐ Radiation	Right	Left		
☐ Reduction	Right	Left		
☐ Implants	Right	Left		

☐ Saline ☐ Silicone ☐ Pre-pectoral ☐ Retro-pectoral

Have you or anyone in your family been diagnosed with breast cancer? ☐ Yes ☐ No
Who was diagnosed? ☐ Myself ☐ Mother ☐ Sister ☐ Daughter ☐ Grandmother ☐ Aunt

Please circle which best applies to you: Non-Smoker Smoker Former Smoker

Do you, or have you used hormone replacement therapy? ☐ Yes ☐ No
☐ Estrogen ☐ Provera ☐ Premarin ☐ Prempro ☐ Tamoxifen
When? Started: _____ Finished: _____ Still Using? ☐ Yes ☐ No

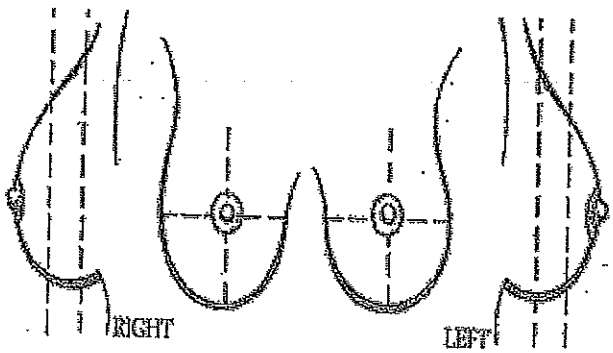
Are you pregnant? ☐ Yes ☐ No
Have you ever been pregnant? ☐ Yes ☐ No **If yes, how many children?** _____

Age of Hysterectomy _____ Age of Menopause _____ Date of last menstrual period _____

Have you had a weight (increase/decrease) of ten pounds in the last year? ☐ Yes ☐ No

Mammography is an x-ray examination of the breast used primarily to detect cancer. Although mammography is the single best method of detecting breast cancer, it cannot find all breast cancers. Combined with monthly breast self-examinations and yearly clinical exams by your doctor, you can achieve good breast care. In order to obtain the best mammogram, it is essential that the breast be firmly compressed for a few seconds during the examination which may cause some slight discomfort. A radiologist will interpret your films and the results will be sent to you and your doctor. Our technologists will be glad to provide you with additional information on mammography and breast self-examinations.

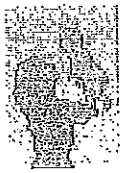
Patient Signature: _____ **Date:** _____



Technologist: _____ **Date:** _____

Gulfport Obstetrical & Gynecological Clinic, P.A.

James H. Gaddy, Jr., M.D. Donald K. Gaddy, M.D. Charles L. Robinson, M.D.



Patient:_____ MRN:_____ Exam Date:_____

Consent to Release Medical Films/Studies/Records

To: Gulfport OB/GYN Clinic
4502 Old Pass Road
Gulfport, MS 39501
Mammography Dept
Phone: 228-678-9135
Fax: 228-248-0325

From: _____
_____
_____
_____
_____

ORIGNAL IMAGES ON CD IN DICOM FORMAT ARE PREFERRED WHEN AVAILABLE. REQUESTING 3 PRIOR MAMMOGRAM STUDIES IF AVAILABLE.

- o Mammogram Images and Reports
- o Ultrasound Reports
- o Breast Biopsy Pathology
- o Reports only, No images needed.

I hereby authorize the release of medical information for diagnostic evaluation and comparison to Gulfport OB/GYN Clinic images. I further authorize the acceptance of a copy, facsimile, or other electronic image of this form bearing my signature to be used for purposes of releasing the information as instructed above. I acknowledge that Gulfport OB/GYN Clinic is not responsible for lost films or films damaged during shipment to or from the facility. This authorization will expire 90 days from the date noted above.

Patient Signature

_____ Social Security # _____

Patient Name_____ Date of Birth: _____

Address_____

City,State,Zip _____