

PLEASE PRINT

DATE: ___/___/___

NAME: _____ AGE: _____

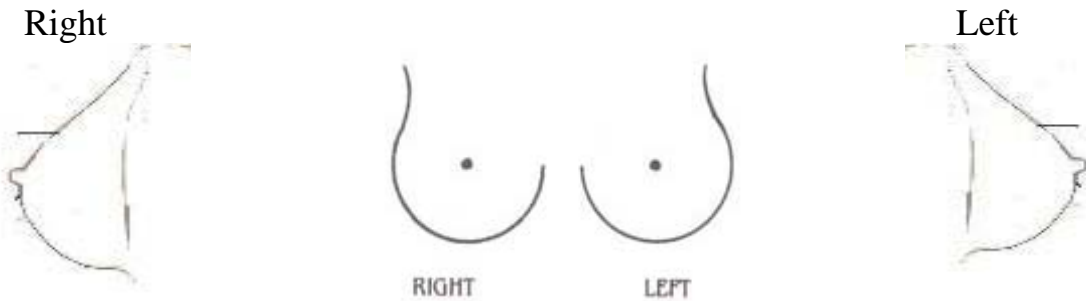
1. Have you had previous breast imaging (Mammo, Ultrasound, MRI): Yes No Date: ___/___/___
Where: Main Street Radiology New York Hosp-Queens Other: Specify _____
Findings: _____
2. Last menstrual period: ___/___/___ Hormone pills: No Yes - Duration: _____
3. When was your last breast examination by a physician? _____
4. Prior Breast Surgery/Biopsy: No Yes - Date of most recent surgery: ___/___/___
 Right breast Left breast
Reason: Surgical biopsy Mastectomy Lumpectomy Reduction Implants
5. Have you had Radiation Therapy? No Yes
6. Have you had Chemotherapy? No Yes
7. History of Breast Cancer:
 None Self Mother Daughter Sister
8. Reason for exam: (please check all that apply)

<input type="checkbox"/> Yearly Routine	<input type="checkbox"/> Soreness <input type="checkbox"/> Swelling (611.72)	<input type="checkbox"/> Lump or Mass (611.72)	
<input type="checkbox"/> Nipple Discharge	<input type="checkbox"/> Micro calcification 793.81	<input type="checkbox"/> Follow-up for problem/biopsy	
<input type="checkbox"/> Skin Changes	<input type="checkbox"/> Follow up Ultrasound/MR finding (793.89)	<input type="checkbox"/> Follow up mammo finding(793.80)	

Other: _____

I have reviewed the above information. Signature: X _____

*****DO NOT WRITE BELOW THIS LINE*****



Findings:

Technologist: _____

Radiologist: _____

updated 4/09

(718) 428-1500

MSR MAIN STREET RADIOLOGY

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