



PATIENT INTAKE FORM - B

Please print legibly

Date: ___/___/___ Name: _____

Last Name First Name Middle Initial

Date of Birth: ___/___/___ Test Scheduled: _____

Age Height Weight

Why did your doctor order this test: _____

List previous tests performed at Manhattan Diagnostic Radiology and when they were performed: _____

List previous surgical procedures and date performed: _____

When was your last menstrual period? _____

Is there any chance that you may be pregnant now? [] Yes [] No

Since your last visit to this office -

1. Have you had breast surgery? [] Yes [] No

2. Have you become menopausal? [] Yes [] No

3. Have you had any children? [] Yes [] No

a. If yes, how many? _____

4. Are you taking any hormones? [] Yes [] No

a. If so when did you start? _____

5. Have you stopped taking hormones? _____

a. If so when did you stop? _____

6. Has anyone in your family developed breast cancer? [] Yes [] No

a. If so, who and at what age? _____

7. When was your last physical breast exam performed by your doctor or gynecologist (month/yr)? _____

8. Are you taking any medications, especially prescription blood thinners such as Coumadin? [] Yes [] No

a. If so, what are they? _____

I attest that, to the best of my knowledge, the above information is correct. I read and understand the contents of this form and have had the opportunity to ask questions regarding the information on this form and the procedure that I am about to undergo. I give permission for the following test(s) to be performed: _____

Patient Signature

Patient Name

Date

WOMEN OF CHILDBEARING AGE - PLEASE FILL OUT THE SECTION BELOW

In order for us to complete the study that has been requested by your physician, we may be required to take x-rays of a certain area of your body. It has been hypothesized that an unborn child in its 1st trimester would be more sensitive to radiation than an adult. In order to ensure that no fetus (unborn child) be exposed to radiation, please complete the following questions below.

Are you pregnant or experiencing a late menstrual period? [] Yes [] No Date of last menstrual period _____

Is there any chance you may be pregnant? [] Yes [] No Are you breast feeding? [] Yes [] No

To the best of my knowledge, I am not pregnant, and I have been informed of the effects of radiation on an unborn child and consent to having the x-rays taken. _____

Patient Signature

Patient Name

Date