

The Women's Clinic

Obstetrics, Gynecology & Mammography

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X-Ray # _____

Today's Date _____

Patient's Name _____ Age _____ Date of Birth _____

Phone Number: (____) _____ Referring Physician: _____

I, _____, state that as of the above date, I am not pregnant.

TECHNOLOGIST COMMENTS

- ◆ Have you had a previous mammogram? **YES** **NO**
Where? _____
- ◆ Are you experiencing any NEW breast problems? **YES** **NO**
- ◆ Have you previously had any breast surgeries? **YES** **NO**
Breast biopsy/Mastectomy/Reduction/Aspiration/
Implants/Lumpectomy Right Left
- ◆ Have you ever been diagnosed with ANY type of cancer? **YES** **NO**
If yes, explain: _____
- ◆ Have you had a hysterectomy? **YES** **NO**
If yes, at what age? _____
- ◆ Are you taking hormones now? **YES** **NO**
- ◆ Are you taking birth control pills? **YES** **NO**
- ◆ Do you have any family history of breast cancer? **YES** **NO**
If yes, who _____
- ◆ Age at the time of your first menstrual period _____
- ◆ Age at time of your first pregnancy _____
- ◆ Date of last menstrual period, if applicable _____

Your mammogram will be read by the physicians of GMN Associates, specialists in women's breast imaging. You will receive a separate bill for their service. *Please initial that this statement has been read.* _____ (patient's initials)

If your mammogram demonstrates that you have dense breast tissue, which could hide abnormalities, and you have other risk factors for breast cancer that have been identified, you might benefit from supplemental screening tests that may be suggested by your ordering physician. Dense breast tissue, in and of itself, is a relatively common condition. Therefore, this information is not provided to cause undue concern, but rather to raise your awareness and to promote discussion with your physician regarding the presence of other risk factors, in addition to dense breast tissue. A report of your mammography results will be sent to you and your physician. You should contact your physician if you have any questions or concerns regarding this report.

Patient's Signature _____

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TECHNOLOGIST COMMENTS

Physical Findings

