Mammography Patient Questionnaire

Office use only

Appointment Time: _____ Ordering Provider: _____ Patient ACCT#: _____

Please answer ALL questions

Patient Name: _____ Date: _____

DOB: _____ Age: _____ Height: _____ Weight: _____

Home Number: _____ Ordering PCP: _____ Cell Number: _____

Previous Mammogram at Aylo Health- Imaging Center? ☐ Yes ☐ No When? _____

☐ If no, where was your previous Mammogram performed? _____ When? _____

What was your age at your first menstrual period? _____ When was your last period? (Date or Age) _____

What was your age at menopause? _____

Have you had a hysterectomy? (Check one) ☐ Yes ☐ No ☐ Partial ☐ Complete

Have you ever had Hormone Replacement Therapy? ☐ Yes ☐ No If so, how long? _____

How many pregnancies have you had? _____ What was your age when you delivered your first child? _____

Have you ever taken birth control pills or other hormones? ☐ Yes ☐ No If yes, for how long? _____

Are you pregnant or breastfeeding? ☐ Yes ☐ No Did you breastfeed? ☐ Yes ☐ No

Have you ever had chemotherapy? ☐ Yes ☐ No Have you ever had radiation treatments? ☐ Yes ☐ No

Personal history of Ovarian Cancer? ☐ Yes ☐ No

Has anyone in your family had Ovarian Cancer? ☐ Yes ☐ No

If yes, Who? _____ Age at diagnosis? _____

Personal history of Breast Cancer? ☐ Yes ☐ No

Has anyone in your family had Breast Cancer? ☐ Yes ☐ No

If yes, Who? _____ Age at diagnosis? _____

Have you ever had ANY of the following breast surgeries? Check all that apply.

Biopsy (surgical/incision)	☐ Rt	☐ Lt	Date_____	☐ Benign	☐ Positive
Biopsy (needle)	☐ Rt	☐ Lt	Date_____	☐ Benign	☐ Positive
Cyst Aspiration	☐ Rt	☐ Lt	Date_____		
Lumpectomy (for breast cancer)	☐ Rt	☐ Lt	Date_____		
Mastectomy	☐ Rt	☐ Lt	Date_____		
Implants	☐ Rt	☐ Lt	Date_____		
Breast Reduction	☐ Rt	☐ Lt	Date_____		

Any other breast procedures? ☐ Yes ☐ No If yes, please explain _____

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Mammographer Comments: _____

Mammographer Signature: _____

Any symptoms or problems currently? _____

Authorization For Release Of Mammogram/Ultrasound Images

Date: _____

☐ My previous Mammogram was done at Aylo Health Imaging Center

☐ My previous Mammogram was NOT done at Aylo Health Imaging Center

Facility of Previous Mammogram Films:

Facility Name: _____

Street Address: _____

CITY STATE ZIP CODE

Phone: _____ Fax: _____

Last name at time of previous mammogram: _____

***Please note, your exam will be held for 14 days prior to being read by the radiologists. Aylo Health will make all attempts to acquire previous mammogram films for comparison.**

I hereby authorize the practitioner of the facility listed above to release my **mammogram/breast ultrasound films/pathology results** via mail or powershare to

Aylo Health
Imaging at Stockbridge
1100 Hospital Drive
Stockbridge, GA 30281

Phone: 678-432-6161 Ext. 13144 **Fax:** 678-432-3677

This authorization is valid from the date of my or my representative's signature below and shall expire in 366 days unless otherwise noted by me or my representative.

PATIENT NAME _____ DATE OF BIRTH _____

SIGNATURE OF PATIENT _____ DATE _____

NAME OF REP. _____ SIGNATURE _____ DATE _____

Releasing facility: please fax this form to Aylo Health, Imaging Services.

Images PowerShared on: _____ Films/Images on CD/DVD Mailed on: _____ No record in our system - Initial _____

Mammogram Informed Consent

Please read each paragraph carefully and sign and date the form.

- I understand that all screening mammograms performed at Aylo Health include **3D Tomosynthesis Imaging.**
- I understand that a mammogram is only 90% accurate in detecting breast cancer and is only a partial examination for diagnosing breast cancers.
- I understand, based on my clinical symptoms, I may be referred for a diagnostic mammogram, ultrasound or to a surgeon. The diagnostic mammogram and ultrasound is not considered preventative and would be billed as separate studies.
- I understand that I am responsible for getting my results if I have not heard from my physician after 2 weeks.
- I understand periodic breast examinations should be done by a physician.
- I understand if after seeing my physician I continue to have breast problems, regardless of a negative report on the mammogram, I will contact my physician for instructions on further follow up.
- I understand some redness and/or tenderness of my breasts may occur following the mammogram due to the compression device necessary for good images, but these symptoms should be gone within 24 – 48 hours.
- I understand a mammogram does require the use of low dose radiation; therefore, I will inform the technologist if I think I might be pregnant.

PATIENT SIGNATURE _____ DATE _____

PATIENT NAME (PLEASE PRINT) _____

WITNESS _____ DATE _____

Insurance Waiver

Date: _____

Patient Name: _____

Provider Name: _____

I understand the mammogram performed on the above date may not be covered by my insurance company due to:

- ☐ It may not have been a full year since my last screening mammogram and I understand my insurance only covers 1 screening per year.
- ☐ I am under the age of 40 and I understand mammograms are recommended starting at age 40.
- ☐ Provider is not recognized under my insurance plan. I understand that I may be using an out of network provider for these services.
- ☐ None of the circumstances listed above apply to me

I elect to receive services today and agree to pay any and all of the balance due related to this procedure if not covered by insurance.

_____

SIGNATURE OF PATIENT OR PERSON REPRESENTED BY SAID INSURANCE PLAN

IF WE CANNOT VERIFY YOUR INSURANCE, YOU WILL BE CONSIDERED SELF PAY