



*Office Use Only:*

APPOINTMENT TIME: \_\_\_\_\_  
ORDERING PROVIDER: \_\_\_\_\_  
PATIENT ACCT#: \_\_\_\_\_  
3D TOMOSYNTHESIS? \_\_\_\_\_

## Mammography Patient Questionnaire

**Please answer ALL questions.**

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_

Weight: \_\_\_\_\_ Ph#: \_\_\_\_\_ Ordering PCP: \_\_\_\_\_ Ph#: \_\_\_\_\_

Previous Mammogram? Yes \_\_\_\_\_ No \_\_\_\_\_ If Yes, Where? \_\_\_\_\_ 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 \_\_\_\_\_

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 \_\_\_\_\_ or 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 \_\_\_\_\_

Any symptoms or problems currently? \_\_\_\_\_

### **FOR OFFICE USE ONLY**

Mammographer Comments:





## MAMMOGRAM INFORMED CONSENT

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

- 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 are 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's Signature

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Name (Please Print)

\_\_\_\_\_  
Witness

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

*Aylo Health - Imaging at Stockbridge  
1100 Hospital Drive, Stockbridge, GA  
30281 Phone: 678-432-6161 Fax:  
678-432-3677*



**AUTHORIZATION FOR RELEASE  
OF MAMMOGRAM/ULTRASOUND IMAGES**

Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**Facility of Previous Mammogram Films:**

**Facility Name:** \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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 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** to

**Aylo Health - Imaging at Stockbridge  
1100 Hospital Drive  
Stockbridge, GA 30281  
Ph. 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 at Stockbridge.**

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



## 3D Mammogram Upgrade

3D Mammography is a new screening and diagnostic tool designed for early breast cancer detection.

During the 3D portion of the exam, the X-ray arm sweeps in a slight arc over your breast, taking multiple images. This provides greater detail, allowing the radiologist to examine your breast tissue in one millimeter slices. They can scroll through images of your entire breast like pages of a book.

The additional 3D images make it possible for a radiologist to gain a better understanding of your breast tissue and possibly reduce the need for follow-up imaging.

3D mammography complements standard 2D mammography and is performed the same way as the 2D system. Compression is still required and takes a few more seconds.

**\*The 3D Mammogram may not be covered by insurance but we will submit the claim to your insurance company. If it is not covered, you will be billed the cost of the 3D mammogram at a later date. The cost of this procedure is \$60.00.**

**Yes**, I would like the 3D Imaging. I acknowledge that the 3D mammogram may not be covered by my insurance company and that the fee associated will be my responsibility.

**No**, I choose not to have the 3D Imaging. I acknowledge I will have 2D Imaging.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

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## 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 are considered Self Pay\***

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