BREAST IMPLANT HISTORY

Name: _____ Age:_____ Date:_____

Doctor: _____ Imaging Center: _____

Reason for this examination: _____

Have you ever had a mammogram/ultrasound before? ___ Yes ___ No When? _____ Where? _____

Have you ever had a Breast MRI before? ___ Yes ___ No When? _____ Where? _____

1. **PHYSICAL IMPLANT**

		Right	Left
Silicone?	___ Yes ___ No	_____	_____
Saline?	___ Yes ___ No	_____	_____
Single Lumen?	___ Yes ___ No	_____	_____
Double Lumen?	___ Yes ___ No	_____	_____
Retro-pectoral (behind chest muscle)?	___ Yes ___ No	_____	_____
Retro-glandular (over chest muscle)?	___ Yes ___ No	_____	_____

Type of Implant(s): _____

Date(s) of Surgery: _____

2. **BREAST SURGICAL/ IMPLANT HISTORY:**

		Right	Left
Did you have steroid solution placed with the original implant(s)?	___ Yes ___ No	_____	_____
Did you have silicone or paraffin injections in your breast(s)?	___ Yes ___ No	_____	_____
Did you have silicone or steroid injections in your breast(s)?	___ Yes ___ No	_____	_____
Are you planning to have your breast implant(s) removed?	___ Yes ___ No	_____	_____

3. **GENERAL HISTORY:**

Are you pre-menopausal? ___ Yes ___ No Date of last menstrual period: _____

Pre-menopausal patients should be scheduled between days 7-10 from the 1st day of last menstrual period.

Day of cycle today: _____

Are you post-menopausal? ___ Yes ___ No _____

Are you on hormone replacement therapy? ___ Yes ___ No _____

If you quit taking hormone replacement therapy, how long ago did you quit? _____

Please indicate symptoms: _____

_____

OFFICE USE ONLY

Clinical Findings

Clinical indications/Notes:

_____

_____

_____

_____

Technologist's Name:_____

1. On review of your screening mammogram, if an area needs further evaluation, we will contact you to schedule an appointment. (There is an additional charge for these views).
2. If an ultrasound exam is recommended, this is considered a separate study and is billed separately.
3. In the event that additional views and/or breast ultrasound is performed on the same day as your screening mammogram, be aware that there is an additional charge for these exams.

PLEASE BE ADVISED THAT A DIAGNOSTIC MAMMOGRAM AND/OR BREAST ULTRASOUND ARE NOT CONSIDERED TO BE A ROUTINE PREVENTATIVE EXAM AND MAY INCUR ADDITIONAL OUT OF POCKET EXPENSE.

To the best of my knowledge, all of the above is true and correct.

Patient Signature: _____ Date:_____