CHESAPEAKE MEDICAL IMAGING

Patient Name:_____ **DOB:**_____

Last Mammogram (MO/YR): _____ **Facility Name:** _____

REASON FOR VISIT:

- R / L ☐ Annual/Screening
- R / L ☐ Call back/Follow-up
- R / L ☐ Pre-op clearance
- R / L ☐ New Lump
- R / L ☐ Nipple Discharge
- R / L ☐ New onset Breast Pain
- R / L ☐ Abnormal outside study

Personal History:

- R / L ☐ Breast Implants
- R / L ☐ Breast Reduction
- R / L ☐ Needle Biopsy
- R / L ☐ Excisional Biopsy
- R / L ☐ Personal Breast Cancer
- R / L ☐ Lumpectomy
- R / L ☐ Mastectomy
- R / L ☐ Radiation Therapy
- R / L ☐ Chemotherapy

Are you post menopausal? **Yes / No**
Are you currently on any hormone therapy? If yes, please indicate length of time in months or years: _____
Age at first period: _____ **Number of Children Birthed:** _____ **Live birth after 30:** _____

The below section will be completed by the TECHNOLOGIST:

Breast Cancer before age 50 Yes / No
☐Mother's side ☐Father's side Age at Diagnosis_____ Relation_____

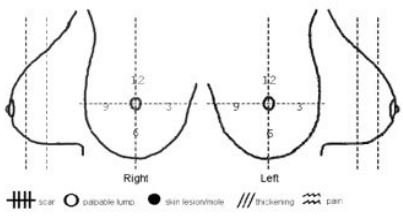
Breast Cancer after age 50 Yes / No
☐Mother's side ☐Father's side Age at Diagnosis_____ Relation_____

Male Breast Cancer Yes / No
☐Mother's side ☐Father's side Age at Diagnosis_____ Relation_____

Ovarian Cancer Yes / No
☐Mother's side ☐Father's side Age at Diagnosis_____ Relation_____

Uterus/Endometrium Cancer Yes / No
☐Mother's side ☐Father's side Age at Diagnosis_____ Relation_____

Other Cancer Yes / No
☐Mother's side ☐Father's side Age at Diagnosis_____ Relation_____



CHESAPEAKE MEDICAL IMAGING

Please select the CMI location below where you would like you prior imaging to go:

☐ 122 Defense Highway Suite 102 Annapolis, MD 21401

☐ 401 Purdy Street Suite 104 Easton, MD 21601

TEL: 855-455-8900
SECURE FAX: 855-455-8222

Important Notice:
My signature authorizes the release of medical records and imaging studies to Chesapeake Medical Imaging at the above location. Please mail a CD to the address above. Thank you!

Patient Name:_____DOB:_____Age:_____

_____

Patient Signature Date