

# THE WOMEN'S CENTER AT MERCY

4300 WEST MCAULEY BOULEVARD OKLAHOMA CITY, OK 73120  
405.752.3500 FAX: 405.936.5217

Date \_\_\_\_\_

Name \_\_\_\_\_ Date of birth \_\_\_\_\_ Age \_\_\_\_\_  
LAST FIRST MIDDLE

Previous name (if applicable) \_\_\_\_\_

Referring physician \_\_\_\_\_ Other physician \_\_\_\_\_

Have you had a previous mammogram? .....  No  Yes      Date of last mammogram \_\_\_\_\_  
 Name used for previous mammogram \_\_\_\_\_  
 Where was it performed? \_\_\_\_\_  
 Results:  Negative  Positive Explain \_\_\_\_\_

Are you or could you be pregnant? .....  No  Yes      Age at first pregnancy \_\_\_\_\_  
 No. of pregnancies \_\_\_\_\_ No. of children \_\_\_\_\_

Did you breast feed? .....  No  Yes  
 Do you take hormones? .....  No  Yes      If yes, how long? \_\_\_\_\_

Has dosage changed since last mammogram? .....  No  Yes

Do you have a family history of breast cancer? .....  No  Yes

Self ..... Age at diagnosis \_\_\_\_\_  
 Mother ..... Age at diagnosis \_\_\_\_\_  
 Sister ..... Age at diagnosis \_\_\_\_\_  
 Other family member ..... Relation \_\_\_\_\_  
 Mother's side  Father's side  Before age 50

Have you had breast surgery? .....  No  Yes

Needle biopsy .....  Right Mo/yr \_\_\_\_\_  Left Mo/yr \_\_\_\_\_  
 Surgical biopsy .....  Right Mo/yr \_\_\_\_\_  Left Mo/yr \_\_\_\_\_  
 Cyst drained .....  Right Mo/yr \_\_\_\_\_  Left Mo/yr \_\_\_\_\_  
 Reduction .....  Right Mo/yr \_\_\_\_\_  Left Mo/yr \_\_\_\_\_  
 Implants .....  Right Mo/yr \_\_\_\_\_  Left Mo/yr \_\_\_\_\_  
 Lumpectomy for breast cancer ..  Right Mo/yr \_\_\_\_\_  Left Mo/yr \_\_\_\_\_  
 Radiation for breast cancer .....  Right Mo/yr \_\_\_\_\_  Left Mo/yr \_\_\_\_\_  
 Mastectomy .....  Right Mo/yr \_\_\_\_\_  Left Mo/yr \_\_\_\_\_

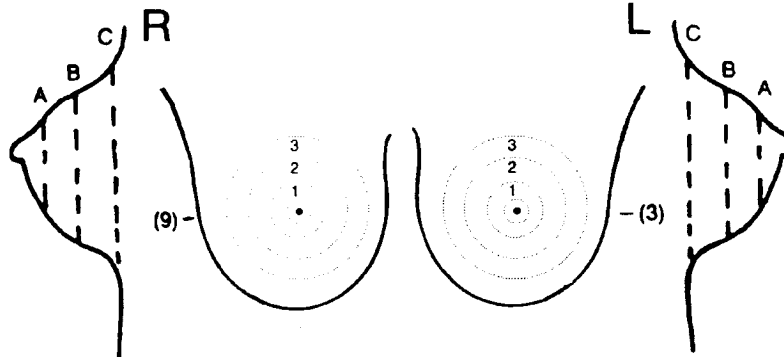
Do you have any current breast problems? .....  No  Yes

Lump .....  Right  Left  
 Pain .....  Right  Left  
 Nipple secretion .....  Right  Left  
 Other: please describe \_\_\_\_\_

Do you perform breast self-examination? .....  No  Yes      Would you like to view the BSE tape? .....  No  Yes

DO NOT WRITE IN THIS SPACE

FOR OFFICE USE ONLY



RT Signature \_\_\_\_\_

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OKLAHOMA CITY, OKLAHOMA 73120

DEPARTMENT OF RADIOLOGY

## RELEASE OF RECORDS

Date \_\_\_\_\_

I hereby authorize \_\_\_\_\_  
(name of physician/institution)

to release to The Women's Center at Mercy film(s) and report(s) of my

\_\_\_\_\_ performed at your institution.  
(examination)

Signature of patient / legal guardian \_\_\_\_\_