



CHESAPEAKE MEDICAL IMAGING

122 Defense Highway
Annapolis, MD 21401
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FAX 410.571.9348

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Bowie, MD 20716
TEL 301.262.8282
FAX 301.262.8077

401 Purdy Street
Easton, MD 21601
TEL 410.822.1888
FAX 410.822.6066

Patient Name: _____ **DOB:** _____

Please Print

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 Signature Please

Today's Date

Last Mammogram (month/year): _____ **Facility Name:** _____

Reason for visit:

- ___ 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 R L

Personal History Breast Surgeries:

- ___ None
- ___ Breast Implants R L
- ___ Breast Reduction R L
- ___ Needle Biopsy R L
- ___ Excisional Biopsy R L
- ___ Personal Breast Cancer R L
(age at diagnosis _____)
- ___ Mastectomy R L
- ___ Lumpectomy R L
- ___ Radiation Therapy R L
- ___ Chemo Therapy R L

Personal History:

- Chance of Pregnancy: Y N
- Last Menstrual Cycle: _____
- Post Menopause: Y N
- Removal of Uterus: Y N
- Removal of Ovaries: Y (R L Both) N
- Current Hormone Use Y N
(incl. Birth Control Pills/IUD) If yes, how long? _____
- Number Children Born _____
- Over age 30 for first live birth Y N
- Personal History Breast Cancer Y N
- Personal History Ovarian Cancer Y N

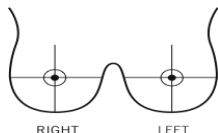
Family History of Breast Cancer:

- ___ None
- ___ Mother (age at diagnosis _____)
- ___ Sister (age at diagnosis _____)
- ___ Daughter (age at diagnosis _____)
- ___ Grandmother (age at diagnosis _____)
(maternal/paternal)
- ___ Aunt (age of diagnosis _____)
(maternal/paternal)

Below line for CMI use only

Technologist notes: _____

Initial for History Verification _____



Technologist Signature

Int. _____ Date: _____

Int. _____ Date: _____

Int. _____ Date: _____

Int. _____ Date: _____