



THE BREAST CARE CENTER

MAMMOGRAPHY INTAKE FORM

Today's date: _____

Patient Information

Patient Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Best contact Number: _____ Home ☐ Work ☐ Cell ☐

Gender (please circle one): MALE or FEMALE SSN : _____

Marital Status: Single ☐ Married ☐ Divorced ☐

Primary Language _____ Ethnicity _____

Emergency Contact

Name: _____ Phone#: _____

Relationship to Patient: _____

Employer and Primary Care Doctor Information

Employer: _____ Phone # _____

Primary Care Doctor: _____

Primary Care Address: _____ Phone: _____

I am a citizen of the US: YES or NO I am a permanent resident of the US: YES or NO

FOR OFFICE USE ONLY:

COVERAGE NAME: _____

POLICY NUMBER: _____

GROUP NAME: _____

MAMMOGRAPHY INTAKE FORM

Patient Health Information

1. Have you ever had a mammogram? Yes ☐ No ☐

If yes, when and where?: _____

2. Do you have any current breast concerns? _____

3. Have you had any breast surgeries or breast biopsies in the past?: Yes ☐ No ☐

If yes, please explain _____

4. Have you PERSONALLY had breast cancer or any other form of cancer?: Yes ☐ No ☐

If yes, when _____

5. Are you of ASHKENAZI Jewish descent?: Yes ☐ No ☐

Do you have implants?: Yes ☐ No ☐

Are you currently or could you be pregnant?: Yes ☐ No ☐

6. Have you or anyone in your family ever tested positive for a BRCA 1 or 2 mutation?:

Yes ☐ No ☐ If yes, who _____

7. Does anyone in your IMMEDIATE family have a history of breast, ovarian or pancreatic cancer?

Yes ☐ No ☐

If yes, who and at what age were they diagnosed _____

I understand that my answers will be reviewed by the radiologist, technologist, and my answers may be reviewed by a genetic professional.

Signature _____ Date _____

FOR OFFICE USE ONLY:

