Saint Joseph HOSPITAL | SCL Health

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: _____

Saint Joseph HOSPITAL | SCL Health

THE BREAST CARE CENTER

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:

_____

_____

_____