OBSTETRICS & GYNECOLOGY OF ATLANTA, P.C.

3890 Johns Creek Parkway
Suite 300
Suwanee, GA 30034

DATE: ____________________
NAME OF INSURANCE COMPANY: ____________________
NAME OF OB/GYN OF ATL DOCTOR: ____________________
X-RAY # (OFFICE USE): ____________________

NAME: ____________________ (Last) ____________________ (First) ____________________ (MI)

SSN: ____________________ DATE OF BIRTH: ____________________ AGE: ____________

ADDRESS: ____________________ (STREET) ____________ (CITY) ________ (STATE) ________ (ZIP)

PHONE: ____________________ (HOME) ____________________ (CELL) ____________________ (WORK)

1. Are you **PREGNANT** now or is there a possibility that you could be pregnant? ❑ YES ❑ NO

2. How many children have you had? ________ How old were you when you had your first child? __________

3. Have you had a prior mammogram? ❑ YES ❑ NO IF YES, when? __________ and where? ____________

4. Are you having any breast problems **NOW**? ❑ YES ❑ NO **IF YES**, mark the problem(s) below.

   a. Distinct lumps in either breast? ❑ Right ❑ Left

   b. Lumpiness (fibrocystic changes)? ❑ Right ❑ Left TECH INITIALS ________

   c. Discomfort, pain or soreness? ❑ Right ❑ Left

   d. Discharge from nipple? ❑ Right ❑ Left How long and what color? ____________

5. Are you taking **Hormones**? ❑ YES ❑ NO If YES, for how long? ____________________

6. Have **YOU** had cancer of the: ❑ None ❑ Breast ❑ Uterus ❑ Ovaries ❑ Other______________

7. Do you have a **FAMILY HISTORY** of breast cancer? ❑ YES ❑ NO **IF YES,** please fill in boxes below**.**

   ❑ Mother Age_____ ❑ Sister Age _____ ❑ Daughter Age _____ ❑ Grandmother Age _____ ❑ Aunt Age _____ ❑ Cousin Age _____

8. Please mark if **YOU** have previously had any of the Breast Procedures below. NONE

   a. **Needle Biopsy** ❑ Right ❑ Left When? ________ b. **Surgical Biopsy** (not cancer) ❑ Right ❑ Left When?________

   c. **Cyst Aspiration** ❑ Right ❑ Left When? ________ d. **Implants** ❑ Right ❑ Left When? _______

   e. **Reduction** ❑ Right ❑ Left When? ________ f. **Lumpectomy (Cancer)** ❑ Right ❑ Left When? _______

   g. **Mastectomy** ❑ Right ❑ Left When? ________ h. **Radiation** ❑ Right ❑ Left When? _______

PATIENT SIGNATURE: ______________________________
I hereby declare that the information provided in this form is true and complete to the best of my knowledge.

For Office Use Only
Tech Initials:
# of Films Taken: ❑ 8x10 ❑ 10x12
Reason for repeat/extra film: ______________________________
____
Clinical Comments: ______________________________