OBSTETRICS & GYNECOLOGY OF ATLANTA, P.C.

975 Johnson Ferry Road, N.E.
Suite 400
Atlanta, GA 30342

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: ________________________________