

Obstetrics & Gynecology of Atlanta

1100 Johnson Ferry Road, N.E.
Suite 800
Sandy Springs, Georgia 30342
Phone 404-252-1137 Fax 404-506-9221

3890 Johns Creek Parkway
Suite 300
Suwanee, Georgia 30024
Phone 678-775-2300 Fax 404-506-9139

ABOUT YOUR MAMMOGRAM

We regret any discomfort that you may experience as a result of breast compression during your mammographic examination. You should not be alarmed if, as a result of the compression, there is some temporary redness involving one or both breasts. Occasionally there will be mild aching as a result of the compression. If this discomfort is bothersome, it may be relieved by aspirin or acetaminophen, which you can take if you are not allergic to either of these medications. It may be helpful for you to know that because of the compression, the pictures of your breast will be much clearer and will be obtained with less radiation than would be possible without the temporary discomfort you will experience.

Mammography is just one step in a screening program resulting in the earliest detection of breast cancer. The mammogram is the single best method of detecting breast cancer, however, it does not find ALL breast cancers, so it is important for you to do breast self-examination on a continuing basis, and to see your doctor whenever he/she recommends.

A radiologist will interpret the mammogram and send a copy of the report to us. We will send you a report of their findings. Please do not be alarmed if it is necessary to obtain a follow-up study or additional views – this simply means the radiologist could not adequately visualize a particular area and would like to get a clearer reading. Approximately 10-15% of mammogram patients may be called for additional views. If this is necessary we will contact you by phone and in writing to advise you of the need for follow-up.

You have been asked to bring your prior mammogram studies performed at other facilities to your appointment today. If you were unable to obtain them before today's appointment, please have the facility mail them to our office. If your prior films have not arrived at our office within two weeks of your appointment we will send your current films to the radiologist for reading. If your prior films arrive after that time, we will send both sets back to the radiologist for an addendum and you will be charged \$40 for your films to be re-read.

We are pleased to offer our mammography services to you. Thank you for allowing us to participate in your medical care. Please acknowledge that you have read and understand the information provided above by signing and dating this form in the space indicated below.

Signature

Printed Name

Date

Obstetrics and Gynecology of Atlanta

DATE: _____

Northside • 1100 Johnson Ferry Road, N.E,
Suite 800 • Sandy Springs, GA 30342

NAME OF INSURANCE COMPANY: _____

Johns Creek • 3890 Johns Creek Parkway
Suite 300 • Suwanee, Georgia 30024

NAME OF OB/GYN OF ATL DOCTOR: _____

X-RAY # (OFFICE USE) _____

NAME: _____
Last First MI

DATE OF BIRTH: _____ AGE: _____ SSN: _____

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? 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
- 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: Breast Uterus Ovaries Other _____

7. Do you have a **FAMILY HISTORY** of breast cancer? IF YES, please fill in boxes below.

<input type="checkbox"/> Mother Age _____	<input type="checkbox"/> Sister Age _____	<input type="checkbox"/> Daughter Age _____	<input type="checkbox"/> Grandmother Age _____	<input type="checkbox"/> Aunt Age _____	<input type="checkbox"/> Cousin Age _____
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8. Mark below Breast Procedures **YOU** have had in the past.

- | | |
|--|---|
| a. Needle Biopsy <input type="checkbox"/> Right <input type="checkbox"/> Left When? _____ | b. Surgical Biopsy (not cancer) <input type="checkbox"/> Right <input type="checkbox"/> Left When? _____ |
| c. Cyst Aspiration <input type="checkbox"/> Right <input type="checkbox"/> Left When? _____ | d. Implants <input type="checkbox"/> Right <input type="checkbox"/> Left When? _____ |
| e. Reduction <input type="checkbox"/> Right <input type="checkbox"/> Left When? _____ | f. Lumpectomy (Cancer) <input type="checkbox"/> Right <input type="checkbox"/> Left When? _____ |
| g. Mastectomy <input type="checkbox"/> Right <input type="checkbox"/> Left When? _____ | h. Radiation <input type="checkbox"/> Right <input type="checkbox"/> Left When? _____ |

PATIENT

SIGNATURE: X _____

I hereby authorize release of my medical records, prior mammograms and pathology reports.

FOR OFFICE USE:

Tech Initials: _____
 # of Films Taken: 8X10 _____ 10X12 _____
 Reason for repeat(s)/extra film: _____

 Clinical Comments: _____

