OBSTETRICS & GYNECOLOGY OF ATLANTA

DATE: _____

NAME OF OB/GYN OF ATL DOCTOR: _____

MR #: _____

☐ **Northside** ☐ **Johns Creek** ☐ **East Cobb**

NAME:_____ _____ _____
Last First Middle

DATE OF BIRTH: _____ AGE: _____

_____ _____ _____ _____
Address City State ZIP Code

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 **NEW** 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**.**

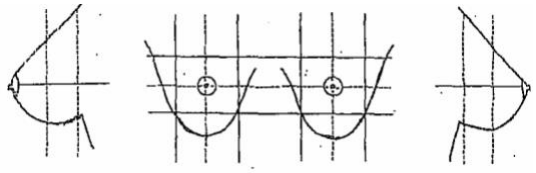
Mother	Sister	Daughter	Grandmother	Aunt	Cousin
@ Age___	@ Age___	@ Age___	@ Age___	@ Age___	@ Age___

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? _____

X 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 Comments:



Right Breast Left Breast