



Hackensack
Meridian Health
Mountainside
Medical Center

**Women's Breast Center
Mammography Worksheet**

Name: _____

Phone number(s)

home # _____

cell # _____

work # _____

▶ Prior mammogram Where? _____

When? _____

▶ **Current Complaints/Symptoms/reason for exam**

lump

Pain

Nipple Discharge

Other

SCREENING Z12.31

no breast complaints

DENSE BREAST R92.2

DIAGNOSTIC

additional images R92.8

short term follow up

h/o ca, lumpectomy 5 years

▶ **Hormone History**

Oral Contraceptives

Estrogen

unspecified hormones

Currently using

Duration of use

____ yrs ____ mos

____ yrs ____ mos

____ yrs ____ mos

Patient Signature _____

Tech's Initial _____

Mammo History

Image Documentation (Breast Complaints)

History (Family h/o ca, OB/Gyn, Medical, biopsies, & surgeries)

OB/Gyn Status (LMP, pregnancy, & breastfeeding)

Notes

Implants (end exam)



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Women's Breast Center
PREGNANCY EVALUATION AND CONSENT FORM

Name: _____

In order to fully evaluate your medical condition your doctor has requested that the following x-ray examination(s) be performed

Last menstrual period _____

Are you now, or is it possible that you might be pregnant? **YES** **NO**

IF YES, how many weeks / months: _____

Have you breast fed in the past 3 months **YES** **NO**

Your doctor has that the requested examination (s) are necessary in determining your medical diagnosis .
It is his medical opinion that the benefits of the examination (s) are greater than the possible risk.
If the examination will allow, precautions may be taken by shielding the abdomen.

1. To the best of my knowledge, **I am NOT pregnant**

Signature _____ Date _____ Witness _____

2. **I may be pregnant at this time.** I have been informed of the possible effects of radiation to a developing fetus and have consented to the x-ray examination(s) ordered by my physician.

Signature _____ Date _____ Witness _____

3. **I may be pregnant at this time. I do not wish to have an x-ray examination at this time.**

Signature _____ Date _____ Witness _____

