Visit #: _____ Acc#: _____

TUBA CITY REGIONAL HEALTH CARE CORPORATION
Mammography Department
PO Box 600 – 167 N. Main Street
Tuba City, Arizona 86045
T: (928) 283-2702 ext.21215 Fax: (928) 283-1312

BREAST EVALUATION/MEDICAL HISTORY

NAME: _____ MRN: _____ D.O.B: _____

REFERRING PROVIDER (PLEASE PRINT): _____ CLINIC/DEPT: _____

Have you ever had a mammogram? Yes or No When? _____ Where? _____

Premenopausal? Yes or No LMP: _____ Taking Hormones: Yes or No How long?: _____yrs

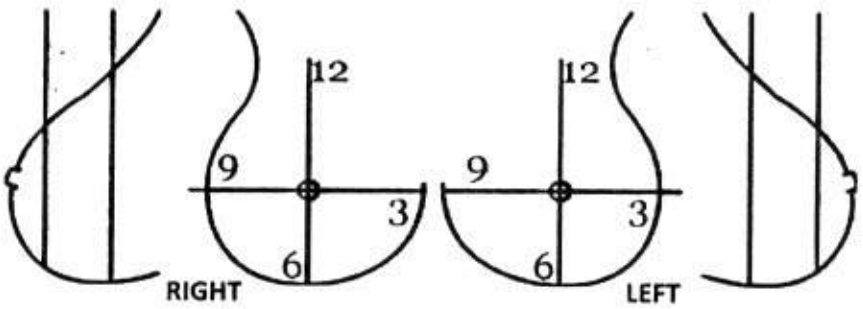
Family History of Breast Cancer: Yes or No If yes, who? _____

Previous Breast Malignancy? Yes or No Right or Left Previous Biopsy? Yes or No Right or Left

Treatment: Lumpectomy Radiation Mastectomy

Clinical Breast Exam: Date: _____

Inverted nipples?	Y/N	R L
Dimpling?	Y/N	R L
Benign biopsy?	Y/N	R L
Implants?	Y/N	R L
Lumps?	Y/N	R L
Pain?	Y/N	R L
Bloody/Watery discharge?	Y/N	R L



EXAM REQUESTED: ☐ SCREENING MAMMOGRAM ☐ DIAGNOSTIC MAMMOGRAM

If requested by Radiologist, please include (please check): ☐ ADDITIONAL IMAGING and/or BREAST ULTRASOUND ☐

Referring Provider Signature: _____ Date of Referral: _____

Comments: _____

PROCEDURE DONE:

_____ 1. Mammo Screening
_____ 2. Mammo Dx Unilat (Right Left)
_____ 3. Mammo Dx Bilat
_____ 4. Breast Ultrasound
_____ 5. Needle Aspiration/Core Bx
_____ 6. Needle Localization

Technologist: _____

Date: _____