diagnostichealth

MALE MAMMOGRAPHY HISTORY AND SCREENING FORM

Patient Name: _____ Date: _____ Age: _____

Patient #: _____ Referring Physician: _____

Exam: ☐ Bilateral ☐ Unilateral ☐ Right ☐ Left

MEDICAL HISTORY:

☐ Baseline ☐ Routine ☐ Follow-Up ☐ Problem

Have you had a previous mammogram? ☐ Yes ☐ No

If Yes, Location and Date: _____

Have you been examined by your doctor? ☐ Yes ☐ No

If Yes, When? _____

Do you have a history of breast cancer? ☐ Yes ☐ No

If Yes, Who? _____

List All Medications You Are Currently Taking: _____

_____

_____

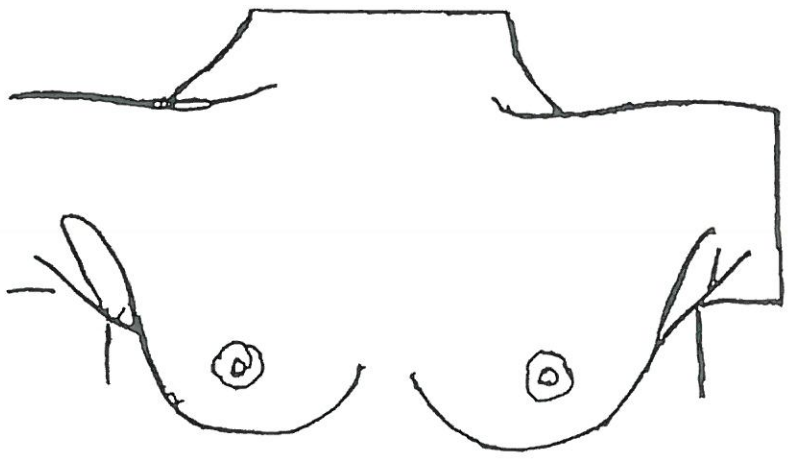
CURRENT PROBLEMS / SYMPTOMS:

	Right	Left	Explain
Pain in breast:	☐	☐	_____
Mass or Lumps:	☐	☐	_____
Discharge:	☐	☐	_____
Swelling:	☐	☐	_____
Axillary Masses:	☐	☐	_____

Male Patient History: _____

_____

_____



COMMENTS: _____

_____

_____

_____

_____

Breast self-examination instructions given? ☐ Yes ☐ No

☐ Verbal ☐ Booklet ☐ Video

Technologist Signature: _____

Mammography is an image of the breast, used largely to detect breast cancer, and is done with a special x-ray machine and compression of the breast. At times, compression of the breast by the machine may cause temporary berast discomfort and / or bruising in some patients. Although mammography is an effective method to detect breast cancer when it is early and still too small to be felt, a mammogram does **NOT** detect 100% of breast cancers. The reported findings of your mammogram must be evaluated by your pesonal physician in conjunction with your clinical or physical findings, because not all cances are visible on mammography. Some cancers may be detected only on physical examination and / or self-examination, and other breast cancers may not be detected early with any of these exams. The information reported by a radiologist on your mammogram will very often help your doctor in deciding the meaning of certain physical findings, and help to determine the best course of action. By signing this form below I acknowledge that I have read, or had read to me, and understand the above information.

Signature: _____ Date: _____

ALLIANCE HEALTHCARE RADIOLOGY

OUT-PATIENT FALL RISK ASSESSMENT

PATIENT NAME: _____ DATE: _____

DATE OF BIRTH: _____ SITE NAME: Diagnostic Health Alaska

INTERVIEWER NAME: _____ CUSTOMER NUMBER: _____

Patient: The following questions are intended to identify patients who may be at risk of falling and to help avoid potential injury. This procedure has been implemented to ensure your safety and to enable us to provide you with the best possible patient care.
Please circle the appropriate answer to each question below. Our staff will go over these questions with you prior to your examination to address any questions or concerns you may have.

1. Have you fallen recently (within the last 3 months)?	YES	NO
2. Do you use a cane, walker or other device to help you walk?	YES	NO
3. Do you require assistance to stand up?	YES	NO
4. Have you taken any medications today for anxiety or to relax you? If yes, what medication? _____ Dosage _____ Time _____	YES	NO
5. Are you dizzy, lightheaded, weak in your legs or unable to see or hear clearly?	YES	NO

Team Member: All patients must be assessed for falls risk prior to transporting patients from the waiting area. If the patient, patient's family member or caregiver answers "yes" to any of the above questions, transport the patient via wheelchair to the imaging system or exam/treatment room.
Retention:

- Wheelchair Refusal: When the fall risk assessment determines a patient must use a wheelchair and the patient refuses, the entire form must be completed, signed and retained in the patient's medical record.
- Mobile Units Only- If the lift or roll/slide door is inoperable and the unit's stairs must be utilized, the top portion of this document must be completed and retained in the patient's medical record. If any "yes" answers are provided, the patient may not utilize the mobile unit stairs and must reschedule for a time when the lift/roll/slide door is operable.

RELEASE OF LIABILITY

Notwithstanding the evaluated risk of fall and Alliance's offer/recommendation to use a wheelchair for transport to/from the imaging system or exam/treatment room, I decline the use of a wheelchair. By declining the use of wheelchair for transport to/from the imaging system or exam/treatment room, I agree, acknowledge and assume all inherent risk including but not limited to the risk of falling, personal injury, damage to personal property, or otherwise. I, on behalf of myself, heirs and/or representatives, do hereby waive and agree to release and hold harmless Alliance HealthCare Services, Inc., its officers, agents, subsidiaries and employees from any and all liability for any damage, claim or injury to myself or my property or otherwise.

PATIENT SIGNATURE: _____

_____ _____

WITNESS SIGNATURE: TITLE

