DIAGNOSTIC HEALTH ALASKA

Alaska's Home for Medical Imaging Since 1984

FEMALE MAMMOGRAPHY HISTORY AND SCREENING FORM

Patient MRN:

Date:

Date of birth:

Patient Name:

Address:

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Type of study: Is this your first mammogram? ☐ Yes ☐ No If no, and not at Diagnostic Health, where and when were they done?

_____

Reason for today's visit: If you are experiencing any **problems** today, please indicate:

☐ Baseline mammogram	☐ Mass or lump	☐ L ☐ R	☐ Nipples retracted / inverted	☐ L ☐ R
☐ Routine (yearly)	☐ Axillary mass (armpit)	☐ L ☐ R	☐ Dimpling of breast	☐ L ☐ R
☐ Follow-up exam	☐ Enlargement / swelling:	☐ L ☐ R	☐ Discharge	☐ L ☐ R
☐ Problem	☐ Tenderness / Pain	☐ L ☐ R	☐ Other _____	☐ L ☐ R

Have you had any breast procedures done? If so, please indicate type, side, and date performed.

☐ Biopsy	☐ L ☐ R	_____	_____
☐ Lumpectomy (cancer:)	☐ L ☐ R	_____	_____
☐ Mastectomy	☐ L ☐ R	_____	_____
☐ Lymph nodes removed	☐ L ☐ R	_____	_____
☐ Chemotherapy	☐ L ☐ R	_____	_____
☐ Radiation	☐ L ☐ R	_____	_____
☐ Implants	☐ L ☐ R	_____	
☐ Reductions	☐ L ☐ R	_____	
☐ Aspiration	☐ L ☐ R	_____	

Have you ever had implants? _____

Have you ever been told you have breast cancer? Please indicate date, side, and type if known.

_____

Have any of your relatives been diagnosed with breast cancer? Please indicate relationship and age of diagnosis.

_____

_____

Are you currently pregnant? ☐ Yes ☐ No Number of pregnancies? _____ Number of live births _____

Are you currently nursing? ☐ Yes ☐ No Age at first full term pregnancy _____

Age your period began? _____ Date of last period _____ Age at menopause? _____

Have you had a hysterectomy? Please indicate date.

Have you had your ovaries removed? Indicate side and date.

Are you currently taking hormones and for how long?

Indicate type	Age began	Currently taking?	Age stopped
☐ Estrogen	_____	☐ Yes ☐ No	_____
☐ Progesterone	_____	☐ Yes ☐ No	_____
☐ Hormonal contraceptives	_____	☐ Yes ☐ No	_____
☐ Tamoxifen	_____	☐ Yes ☐ No	_____

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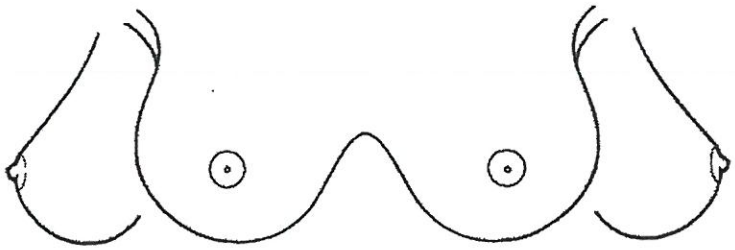
Mammography is an image of the breast, used largely to detect cancer, and is done with a special x-ray machine and compression of the breast. At times, compression of the breast by the machine may cause temporary breast discomfort and/or bruising in some patients. Although mammography is an effective 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 personal physician in conjunction with your clinical or physical findings, because not all cancers are visible on mammography. Some cancers may be detected only on physical examination, and other breast cancers may not be detected with any of these exams. The information reported by a radiologist on your mammogram will very often help your doctor determine the best course of action to take.

I give permission for release of any medical records related to this exam (which are required for quality monitoring purposes) to Diagnostic Health Alaska.

Signature _____ Date _____

TECHNOLOGIST ONLY



CLINICAL NOTES

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TECHNOLOGIST NOTES

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TECHNOLOGIST SIGNATURE _____

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

