



Tech Initials: _____

MRN #: _____

PATIENT INFORMATION

Name: _____ Date of Birth: _____ Age: ____ Date of last mammogram: _____

Reason for today's exam: ☐ First mammogram ever ☐ Annual mammogram

New symptoms may require Doctor's order ☐ New symptom/problem ☐ 6-month follow-up


*Describe your *new* breast problem and how long you have had it (if applicable): _____

MEDICAL INFORMATION AND RISK ASSESSMENT

FAMILY HISTORY

1. Has anyone in your **Family** been diagnosed with **breast** cancer? ☐ Yes ☐ No
- ✓ If Yes, please check the relative and age at time of diagnosis:
- ☐ Mother/Age _____ ☐ Daughter/age _____ ☐ Sister/age _____
- ☐ Aunt/Age _____ ☐ Maternal ☐ Paternal
- ☐ Grandmother/Age _____ ☐ Maternal ☐ Paternal

PERSONAL HISTORY

1. Race:	<input type="checkbox"/> White <input type="checkbox"/> African American <input type="checkbox"/> Hispanic <input type="checkbox"/> Unknown <input type="checkbox"/> Asian-American <input type="checkbox"/> American Indian/Alaskan Native
2. Ethnicity (If applicable):	<input type="checkbox"/> Chinese <input type="checkbox"/> Japanese <input type="checkbox"/> Filipino <input type="checkbox"/> Hawaiian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Other Asian-American
3. Have <i>you</i> previously been diagnosed with breast cancer?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Do <i>you</i> have a history of female cancer? (<i>Ovarian, uterine, cervical</i>)	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Known BRCA1 or BRCA2 mutation or similar genetic syndrome?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Do you take hormones?	<input type="checkbox"/> Yes <input type="checkbox"/> No
✓ If Yes, please check the ones you are currently using:	<input type="checkbox"/> Birth control <input type="checkbox"/> Estrogen <input type="checkbox"/> Progesterone <input type="checkbox"/> Evista
 Length of time on hormones: _____ <input type="checkbox"/> Months <input type="checkbox"/> Years	<input type="checkbox"/> Tamoxifen <input type="checkbox"/> Arimidex <input type="checkbox"/> Testosterone
7. Age at <i>first</i> menstrual period?	<input type="checkbox"/> Age 7-11 <input type="checkbox"/> Age 12-13 <input type="checkbox"/> Age 14 or older
8. Date of your <i>last</i> menstrual period: _____	
9. Are you post menopausal ?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Are you pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Age when you had your first child?	<input type="checkbox"/> No Births <input type="checkbox"/> Under 20 <input type="checkbox"/> Age 20-24 <input type="checkbox"/> Age 25-29 <input type="checkbox"/> Age 30 + <input type="checkbox"/> Unknown

BREAST PROCEDURES

1. History of breast biopsy?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Rt <input type="checkbox"/> Lt Date(s): _____
✓ If Yes, how many times?	<input type="checkbox"/> 1 <input type="checkbox"/> More than 1
Did any of the biopsies show <i>atypical</i> hyperplasia? (or other high risk marker on biopsy?)	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. History of mastectomy?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Bilateral Date: _____
3. History of lumpectomy?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Bilateral Date: _____
4. Treatment:	<input type="checkbox"/> Chemotherapy <input type="checkbox"/> <i>with</i> radiation <input type="checkbox"/> <i>without</i> radiation
5. History of breast reduction surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____
6. History of breast implant surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____

Patient Signature: _____

Date: _____

Patient Name: _____

MRN: _____ DOB: _____

Exam: _____

Referring Provider: _____

DIC Location: _____ Date: _____

Patient's Prior Last Name (If Applicable): _____ ☐ N/A

Please provide the following information so that we may obtain your latest mammogram and/or other breast imaging records for comparison.

Name of Facility: _____

Address of Facility: _____

City/State/Zip: _____

Phone/Fax: _____

I hereby authorize and request you to release all breast imaging, including copies of reports in your possession to Diagnostic Imaging Centers, P.A.

Please print name

X _____
Patient or authorized signature

Date



REPORTS: Please fax reports to our Medical Records Department at (913) 491-9363.
To reach our Medical Records Staff, please call (913) 327-1771 or (816) 531-1771.



IMAGES: If you are unable to cloud images, please mail CD to our Medical Records department.
Diagnostic Imaging Centers, P.A.
6650 W. 110th St. Suite 100
Overland Park, KS 66211

Thank you!



DIAGNOSTIC IMAGING CENTERS, P.A.

Vaccines of all types can result in temporary swelling of the lymph nodes, including under your arm. This swelling is usually a sign that the body is making antibodies and is a normal response. We ask for the following information in case we see a change on your mammogram.

Patient Name: _____

Patient date of birth: _____

Vaccine in the last 90 days : ☐ Yes ☐ No Date of vaccine: _____

☐ Right Arm ☐ Left Arm Type of vaccine: _____



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4911 S Arrowhead Dr #100
Independence, MO 64055

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3937 Sherman Ave
St. Joseph, MO 64506

☐ LEE'S SUMMIT
301 NE Mulberry St #100
Lee's Summit, MO 64086

☐ OLATHE
13795 S Mur-Len Rd #100
Olathe, KS 66062

☐ PLAZA
4801 Main St #200
Kansas City, MO 64112

☐ OVERLAND PARK
6650 W 110th St #100
Overland Park, KS 66211

☐ KC NORTH
303 NE Englewood Rd
Kansas City, MO 64118

☐ WYANDOTTE COUNTY
9201 Parallel Pkwy
Kansas City, KS 66112

☐ LIBERTY
9151 NE 81st Ter #250
Kansas City, MO 64158

☐ MOBILE 3D
MAMMOGRAPHY