Breast Screenings Save Lives!

The Memorial Regional Hospital's Mobile Mammography Van will be at:

10/4/11	SPCC	111 NW 1st Street
10/5/11	ETSD	5680 SW 87 Ave
10/7/11	Police HQ	9105 NW 25 St
10/12/11	WASD	3071 SW 38th Ave
10/14/11	Overtown Transit Village	701 NW 1st

10:00am - 2:00pm

Appointments Required**

Call now to make your appointment

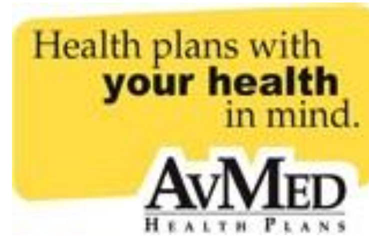
954-276-5595

Monday through Friday 7:30am– 6:00pm

To participate you must be :

- 35 years or older
- Have NO symptoms (new lumps, masses or discharge)
- Have NO personal history of breast cancer
- Not be pregnant or nursing
- Have a written order from your physician/ provider
- Be able to walk up stairs and stand alone

****Participants must bring films from previous mammograms & Dr.'s Prescription to appointment.**



Memorial Healthcare System

NAME: ______________________ DATE: ______________________

ADDRESS: ______________________

HOME PHONE: ______________ WORK PHONE: ______________ CELL PHONE: ______________

REFERRING DOCTOR: ______________________

DATE OF LAST BREAST EXAMINATION BY YOUR DOCTOR? ________ DATE/YEAR OF LAST MENSTRUAL PERIOD? ________

HAVE YOU HAD A MAMMOGRAM BEFORE? YES NO WHERE? ______________ DATE: ______________

HAVE YOU HAD A PET CT BEFORE? YES NO WHERE? ______________ DATE: ______________

HAVE YOU HAD A PET MAMMOGRAM BEFORE? YES NO WHERE? ______________ DATE: ______________

ANY POSSIBILITY THAT YOU MAY BE PREGNANT? YES NO

REASON FOR EXAM TODAY? ______________________

DO YOU FEEL ANY LUMPS TODAY? YES NO RT LT *(symptoms may require extra pictures)*

ANY BREAST PAIN OR SORENESS TODAY? YES NO RT LT

DO YOU HAVE DISCHARGE FROM NIPPLE? YES NO RT LT COLOR: ________ HOW LONG: ________

ARE YOU A DIABETIC? YES NO

HISTORY OF BREAST PROCEDURES? YES NO

IF YES, THEN ANSWER:

- ASPIRATIONS: YES NO RT LT DATE: ________ RESULTS: ________
- NEEDLE BIOPSY: YES NO RT LT DATE: ________ RESULTS: ________
- IMPLANTS: YES NO DATE: ________ TYPE: ________
- REDUCTION: YES NO DATE: ________
- EXCISIONAL BIOPSY (Benign): YES NO RT LT DATE: ________ RESULTS: ________

DO YOU CURRENTLY TAKE **ESTROGEN OR PROGESTERONE**? YES NO

DO YOU HAVE ANY SKIN MOLES, SKIN LESIONS, RASH, SCARS, OR REDNESS ON YOUR BREAST? YES NO

DO YOU, *YOURSELF*, HAVE A PERSONAL HISTORY OF **BREAST CANCER**?
YES NO RT LT DATE: ________ TYPE: ________

IF YES, THEN ANSWER:

- HAVE YOU HAD MASTECTOMY? YES NO RT LT DATE: ________
- HAD LUMPECTOMY FOR CANCER? YES NO RT LT DATE: ________
- HAVE YOU HAD RADIATION THERAPY? YES NO RT LT DATE: ________
- HAVE YOU HAD CHEMOTHERAPY? YES NO DATE: ________

DO YOU, *YOURSELF*, HAVE A HISTORY OF ANY OTHER CANCER? YES NO

IF YES, TYPE OF CANCER AND AGE AT DIAGNOSIS: ______________________

ANY *FAMILY* HISTORY OF CANCER? YES NO

LIST FAMILY MEMBERS WITH BREAST, UTERINE, OVARIAN, COLON, MELANOMA, PANCREATIC OR PROSTATE CANCER:

WHO ______________ THEIR AGE AT DIAGNOSIS: ________ TYPE OF CANCER: ______________

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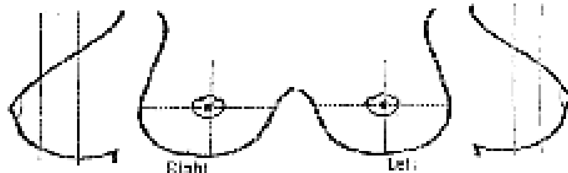
FOR TECHNOLOGISTS TO FILL OUT



● PALPABLE LUMP ○ MOLE/SKIN LESION
/// SCAR ΛΛΛΛ PAIN //// THICKENING

TECHNOLOGIST: MAKE NOTES AND CHART ALL MASSES, MOLES AND SCARS: ______________________