APPOINTMENT TIME: ____________ TIME RECEIVED: ________________ BY: ______________________

MURRAY HILL RADIOLOGY AND MAMMOGRAPHY SIGN IN SHEET

NAME: ____________ MRN: ____________ Today's Date: ____________

DOB: ____________ AGE: ____________ EMAIL: ____________

HOME ADDRESS: ____________

CITY: ____________ STATE: ____________ ZIP: ____________

HOME PHONE: ____________ BUSINESS PHONE: ____________

ETHNICITY *(government required information)* CELL PHONE: ____________

WHITE: ❑ AFRICAN AMERICAN: ❑ ASIAN or PACIFIC ISLANDER: ❑
LATINO/HISPANIC: ❑ AMERICAN INDIAN, ESKIMO,ALEUT: ❑ OTHER RACE: ❑

LANGUAGE PREFERENCE: ________________________________

REFERRING PHYSICIAN'S NAME AND ADDRESS/REPORTS TO BE SENT TO: ____________

TODAY'S EXPECTED PROCEDURE: ❑MAMMO ❑BREAST SONO ❑BREAST MRI ❑PELVIC SONO ❑OTHER
FIRST MAMMOGRAM? ❑YES ❑NO ARE YOU PREGNANT? ❑YES ❑NO

Date of Last Menstrual Period: ________ / ________ / ________

PREVIOUS MAMMOGRAM? WHERE AND WHEN: ____
HAVE YOU HAD A PHYSICAL BREAST EXAM BY YOUR DOCTOR IN THE LAST YEAR? ❑YES ❑NO
HAVE YOU HAD?

Biopsy	❑None	❑Left	Date: _______________	❑Right	Date: _______________
Cyst Aspiration	❑None	❑Left	Date: _______________	❑Right	Date: _______________
Lumpectomy	❑None	❑Left	Date: _______________	❑Right	Date: _______________
Mastectomy	❑None	❑Left	Date: _______________	❑Right	Date: _______________
Radiation Therapy	❑None	❑Left	Date: _______________	❑Right	Date: _______________
Reduction	❑None	❑Left	Date: _______________	❑Right	Date: _______________
Implants (Saline or Silicone)	❑None	❑Left	Date: _______________	❑Right	Date: _______________

DO YOU CURRENTLY HAVE?

Pain	❑None	❑Left	Date: _______________	❑Right	Date: _______________
Lump	❑None	❑Left	Date: _______________	❑Right	Date: _______________
Nipple Discharge	❑None	❑Left	Date: _______________	❑Right	Date: _______________

LIST CURRENT MEDICATIONS & HORMONE REPLACEMENT THERAPY, AND DATE STARTED:

____

FAMILY HISTORY OF BREAST/OVARIAN CANCER? ❑YES ❑NO RELATIONSHIP & AGE OF ONSET:

____

SMOKING STATUS: ❑Current everyday smoker ❑Current some day smoker ❑Former smoker ❑Never smoked
❑Smoker, current status unknown ❑Unknown if ever smoked ❑Heavy tobacco smoker ❑Light tobacco smoker

PAYMENT IS EXPECTED AT TIME OF SERVICE. I will be paying for today's visit by the following methods:
❑Cash ❑Check ❑VISA ❑MASTERCARD ❑AMEX

Patient signature: ____ Date: ______________________

If you have brought previous films or reports with you, please give them to the receptionist before your exam.