**Type of Exam:**
- ☐ Mammogram
- ☐ Procedure/Biopsy
- ☐ Ultrasound
- ☐ Breast MRI

### CURRENT SYMPTOMS

- ☐ NONE

- Breast Pain of Concern
- General Lumpiness
- Lump, felt by patient Date: _______________
- Lump, felt by physician Date: _______________
- Nipple discharge, clear or bloody
- Nipple inversion ☐ New ☐ Chronic
- Skin thickening/retraction
- Breast infection/Abcess
- Abnormal mammogram or ultrasound, follow-up
- Symptoms of implant rupture
- Other: __________________________________________

### PREVIOUS TREATMENT

- ☐ NONE

- Cyst Aspiration
- Reduction Year__________
- Implants Year__________ ☐ saline ☐ silicone
- ☐*Biopsy Year__________ Result__________

### HISTORY OF BREAST CANCER

- ☐ NONE

- Currently being treated for breast cancer
- Lumpectomy Less than 2 Years Ago
- *Lumpectomy More than 2 Years Ago
- Mastectomy
- *Radiation Therapy Year Completed _____________
- *Reconstruction Type:_______________________

### FAMILY HISTORY OF BREAST CANCER

- ☐ NONE

- Mother Age at Diagnosis ___________
- Sister Age at Diagnosis ___________
- Daughter Age at Diagnosis ___________
- Aunt Age at Diagnosis ___________
- Grandmother Age at Diagnosis ___________
- Other: __________________________________________

### CURRENT MEDICATION

- ☐ NONE

- Estrogen # of Years__________
- Progesterone # of Years__________
- Birth Control # of Years__________
- Thyroid Replacement # of Years__________
- Tamoxifen # of Years__________

### MENSTRUAL HISTORY

- Last Menstrual Period _____________
- Age when menstruation stopped _____________

- ☐ Natural ☐ Surgical

### PREVIOUS MAMMOGRAMS

- ☐ NONE

- Beaumont - year_______________
- Outside Facility (complete and sign back of page)

### PATIENT HISTORY OF CANCER (Other than Breast)

- Type: ______________________________________________________________________________________
- Chest/Neck Radiation ☐ Yes ☐ No

### I attest that to the best of my knowledge the above information is correct.

#### PATIENT SIGNATURE: __________________________________________________________________ DATE: ________________________________

**FOR TECHNOLOGIST USE ONLY**

**TECH COMMENTS:** ☐ NO COMPLAINTS

____________________________________________________________

____________________________________________________________

____________________________________________________________

____________________________________________________________

____________________________________________________________

Tech Initials:________

☐ *Can be a screening examination if the patient has no symptoms and the referring MD or patient specifically request a screening exam. Check box.
Beaumont

AUTHORIZATION FOR DISCLOSURE OF PATIENT MEDICAL INFORMATION

Only complete if you have outside films

Patient’s Name ______________________________________________________________ Date of Birth ______________________

Patient Number: ______________________________________

hereby authorizes:

____________________________________________________

____________________________________________________

BREAST CENTER RELEASING INFORMATION

BREAST CENTER RELEASING INFORMATION

____________________________________________________

____________________________________________________

ADDRESS

ADDRESS

____________________________________________________

____________________________________________________

CITY/STATE/ZIP

CITY/STATE/ZIP

its Director or designee, or Medical Information Services Department to release information contained in my patient
records, including alcohol and drug abuse records protected under the regulations in 42 Code of Federal Regulations,
Part 2, if any, psychiatric/psychological services records, and if, and social work records, if any, including
communications made by me to a social worker or psychiatrist/psychologist, and any information regarding
communicable diseases and serious communicable diseases and infections as defined by Michigan Department of
Public Health rule which can include venereal disease, tuberculosis, HIV, AIDS, or ARC, if any, to the individuals or
organizations listed below, only under the conditions listed below:

1. Name of person(s) or organization(s) to whom disclosure is to be made (indicate one):

☐ Beaumont Hospital, Royal Oak
   Imaging Center
   3601 W. 13 Mile Road
   Royal Oak, MI 48073-6769
   Phone: 248-551-7531
   Fax: 248-551-1850

☐ Beaumont Hospital, Troy
   44201 Dequindre
   Troy, MI 48085
   Phone: 248-964-7050 (film room)
   Fax: 248-964-5839

☐ Beaumont Hospital, Grosse Pointe
   468 Cadieux Road
   Grosse Pointe, MI 48230
   Phone: 313-473-1896 (film room)
   Fax: 313-473-1289 (fax)

2. Specific type of information to be disclosed: (if the Radiologist requests)

☐ Please transfer all of my mammogram and breast ultrasound films and reports to the Beaumont facility indicated
above. They will be kept at Beaumont for comparison to my current and future studies. I will notify Beaumont if
and when I want them transferred to another facility.

☐ Please transfer all of my mammogram and breast ultrasound films and reports to the Beaumont facility indicated
above. I would like them transferred back to the original facility as soon as the comparison is made.

3. This authorization is subject to written revocation at any time except to the extent that William Beaumont Hospital
has already taken action in reliance on the authorization. This authorization will expire upon disclosure of requested
information.

Signature of Patient/Authorized Representative __________________________________________________________ Date____________________________

(If authorized representative signature, include paperwork.)

Signature of Parent/Guardian __________________________________________________________ Date____________________________

Signature of Witness __________________________________________________________ Date____________________________