Your employer supports good health and offers this convenient workplace service. We sincerely hope you take advantage of the Novant Health Breast Center mobile mammography services and we welcome the opportunity to partner with you, because a mammogram can save your life.

**Please return the completed paperwork to Human Resources by March 26, 2019.**

For confidentiality, you can seal your completed paperwork in an envelope and write your name and “Mobile Mammography” on the outside of the envelope and send via intracampus mail to Human Resources, or drop off at the HR Building at 2598 Reynolda Rd. If you do not have insurance and need financial assistance, please contact Ashley Hawkins (x.5691) by March 26th.

There are several things you can do to make your exam more accurate, comfortable and efficient:

- On the day of your exam, **avoid the use of heavy creams or powders** and **do not wear deodorant** on the underarms which may interfere with your exam.
- If your breast is sensitive, avoiding caffeine for several days prior to the exam may help.
- If your last mammogram was not through Novant Health Breast Center, make arrangements to get your last mammogram images **by calling the facility that performed your last mammogram and request that your images be sent to us prior to your scheduled exam, or bring your images with you on the day of your exam.** This will help prevent delays in getting a report to your provider and you.
- **Bring a current insurance card and your driver’s license on the date of service to give to the technologist**

Novant Breast Center radiologists follow the guidelines of the American College of Radiology, which states that women should get a mammogram every year after age 40.

Please note that women do not qualify for a mobile screening mammogram if they:

- Are currently breast feeding
- Are pregnant
- Have lumps or other problems with their breasts
- Have a history of recent breast cancer (less than 2 years)
- Had a mammogram within the past 12 months

Breast cancer is a common disease with a high cure rate when detected in time. One out of every seven women will be diagnosed with breast cancer. Although monthly self-breast exams and a yearly clinical breast exam from your healthcare provider are very important, it is through yearly screening mammograms that most early breast cancers will be detected.

Novant Health Breast Center Mobile Staff
Mobile Patient Information Sheet

Date of Service: ______________________

Location: ______________________________

Last Name __________________________ First ________________ Middle ____________ Maiden ____________

Email address: __________________________

Address _______________________________ City __________________________ Zip Code ____________

Social Security # ___________________________ Home # __________________________ Work # ____________

Age ________ Birthdate _______________ Marital Status (circle one) S M D W

Employer __________________________________

Have you ever been a patient at this hospital? ____________ When? ___________________________________

Spouse Name __________________________ Social Security # _______________ Employer ________________

Primary Care Physician __________________________ Address __________________________ Phone ___________

OB/GYN Physician __________________________ Address __________________________ Phone ___________

Primary Insurance _______________ ID# __________________________ Group # ________________

Address __________________________________

Subscriber __________________________ Relationship __________________________ Birthdate ____________

Secondary Insurance _______________ ID# __________________________ Group # ________________

Address __________________________________

Subscriber __________________________ Relationship __________________________ Birthdate ____________

I authorize this facility to file insurance and to obtain medical records necessary.

SIGNATURE __________________________ Date __________ Time __________

WITNESS SIGNATURE __________________________ Date __________ Time __________

If limited English proficient or hearing impaired offer interpreter at no additional cost:

☐ Interpreter Accepted ___________________________________ ☐ Interpreter Refused

(Name/Number of Person/Services Chosen/Used)

NOVANT HEALTH

☐ NHFMC

☐ NHRMC

Mobile Patient Information Sheet

83448  R 07/13/2015    Name / MR # / Label
Breast History

Age: ______  Sex: ______  Height: ______  Weight: ______  Name: ____________________________

Reasons for Today’s Exam
☐ Screening Exam (No Breast Symptoms)
☐ Breast Symptoms if Present: Thickening: R / L / Both  Nipple Retraction: R / L / Both
Skin Problem: R / L / Both  Lump: R / L / Both
Pain: R / L / Both  Discharge: R / L / Both
Swelling: R / L / Both

☐ Follow-up of Previous Exam:  R / L / Both
☐ Other (Describe): ____________________________

Personal History

Yes / No  Previous Mammogram:  Date: ____________________________  Location: ____________________________

Yes / No  Previous Breast Ultrasound:  Date: ____________________________  Location: ____________________________

Yes / No  Previous Breast MRI:  Date: ____________________________  Location: ____________________________

Yes / No  Personal History of Breast Cancer:  R / L / Both  Age/Year: ____________________________

Yes / No  Personal History of Other Cancer:  Type: ____________________________  Age/Year: ____________________________

Yes / No  Have you been tested for the Breast Cancer Genes (BRCA)?
If yes, what were the results?  Positive / Negative

Yes / No  Have you had genetic counseling?

Yes / No  Have you had any of the following Procedures?  If Yes, please indicate below:
Lumpectomy:  R / L / Both  Age/Year: ______  Implants: R / L / Both  Saline/Silicone  Age/Year: ______
Mastectomy:  R / L / Both  Age/Year: ______  Breast Reduction:  R / L / Both  Age/Year: ______
Radiation Therapy:  R / L / Both  Age/Year: ______  Cyst Aspiration:  R / L / Both  Age/Year: ______
Chemotherapy:  R / L / Both  Age/Year: ______  Needle Core Biopsy:  R / L / Both  Age/Year: ______
Tram Flap:  R / L / Both  Age/Year: ______  Surgical Biopsy:  R / L / Both  Age/Year: ______

Date of Last Menstrual Period:
If Post-Menopausal, at what age? ______  Age at First Menstrual Period: ______
Number of Pregnancies: ______  Age at First Pregnancy: ______  Age at First Live Birth: ______

Yes / No  Have you had a Hysterectomy:  Age/Year: ______  Partial: ______  Complete: ______

Yes / No  Are you currently taking Hormones or Birth Control Pills?  Type: ______  Began: Age/Year: ______

Yes / No  Past use of Hormones or Birth Control Pills?  Type: ______
Began: Age/Year: ______  End: Age/Year: ______

Yes / No  Are you currently Breastfeeding, Pregnant, or Possibly Pregnant? ____________
Breast History

Family History of Cancer

Mother: Breast/Ovarian Age: ___________  Grandmother: Breast/Ovarian  Age: ___________
Sister: Breast/Ovarian Age: ___________  Daughter: Breast/Ovarian  Age: ___________
Other Relative: ____________________________________________________________

Yes / No Ashkenazi Jewish Heritage?
Yes / No Do you have MRSA, shingles, latex allergy or a skin rash? _____________________________
Yes / No Do you perform breast self-exams?

Patient’s Signature: ___________________________  Date: ___________  Time: ___________
Referring Provider: ___________________________  Phone: _______________________

(Staff Use Only) Technologist: ___________  Education Provided: _____  Date: _____  Time: ____

Tech Notes:

If limited English proficient or hearing impaired, offer interpreter at no additional cost:

 Interpreter Accepted  Interpreter Refused

(Name/Number of Person/Services Chosen/Used)

Breast History
At Novant Health Breast Center, your breast health is very important to us, and we know that educating you about your specific risk factors is the best first step to preventing breast cancer.

The following questions allow us to assess your lifetime risk of breast cancer. Please answer all questions as completely and accurately as possible.

If you are an established patient in the Novant Health Cancer Prevention & Wellness Clinic you do not need to complete this form. Check here and sign the back and give it to your technologist.

**Personal History**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
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</thead>
<tbody>
<tr>
<td>1) Age: ___________________ Height: ___________ Weight: ___________</td>
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<tr>
<td>2) Have you ever been diagnosed with breast cancer? □ Yes □ No</td>
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<tr>
<td>If Yes, how old were you when you were diagnosed with breast cancer?</td>
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<td>3) Have you had more than one breast cancer? □ Yes □ No</td>
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<tr>
<td>If Yes, how old were you at the time of your first diagnosis?</td>
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<td>4) Have you had a diagnosis of ovarian cancer? □ Yes □ No</td>
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<tr>
<td>If Yes, how old were you at the time of this diagnosis?</td>
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<tr>
<td>5) How old were you when you first started your period?</td>
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<td>6) Have you ever been pregnant? □ Yes □ No If Yes, how old were you at your first live birth?</td>
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<td>7) Are you still having your period? □ Yes □ No If No, how old were you when you stopped?</td>
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<tr>
<td>8) Are you using any type of birth control? □ Yes □ No If Yes, what type? □ Oral □ IUD □ Other</td>
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<td>9) Have you had your uterus removed? □ Yes □ No If Yes, at what age?</td>
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<tr>
<td>10) Have you had your ovaries removed? □ Yes □ No □ Right □ Left □ Both If Yes, at what age?</td>
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<tr>
<td>11) Have you EVER taken hormone replacement therapy? □ Yes □ No</td>
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<td>If Yes, how long have you taken it? If Yes, how many more years do intend to take it?</td>
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<tr>
<td>12) Have you ever had a breast biopsy? □ Yes □ No a. Benign</td>
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<tr>
<td>Where? ___________________ When?</td>
<td></td>
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<tr>
<td>Have you ever had a cyst aspiration? □ Yes □ No a. Hyperplasia</td>
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<tr>
<td>Where? ___________________ When?</td>
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<tr>
<td>If Yes, what were the results of Biopsy?</td>
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<tr>
<td>13) Has anyone in your family already had genetic blood test for breast and/or ovarian cancer risk?</td>
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<td>□ Yes □ No If Yes, who has had testing? ___________ Did they have breast cancer? □ Yes □ No</td>
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<tr>
<td>If Yes, what were the results (circle one): Positive Negative Inconclusive I don’t know</td>
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<tr>
<td>14) Do you have any Ashkenazi Jewish heritage? □ Yes □ No</td>
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<tr>
<td>15) How many daughters do you have? _____________ Adopted/Unknown</td>
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<tr>
<td>A. Current age_____ Did she ever have □ breast or □ ovarian cancer? □ Yes □ No If Yes, at what age?</td>
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<tr>
<td>B. Current age_____ Did she ever have □ breast or □ ovarian cancer? □ Yes □ No If Yes, at what age?</td>
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<tr>
<td>C. Current age_____ Did she ever have □ breast or □ ovarian cancer? □ Yes □ No If Yes, at what age?</td>
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<td></td>
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<tr>
<td>D. Current age_____ Did she ever have □ breast or □ ovarian cancer? □ Yes □ No If Yes, at what age?</td>
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<tr>
<td>16) How many sisters do you have? __________________________ Adopted/Unknown</td>
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<tr>
<td>A. Current age_____ Did she ever have □ breast or □ ovarian cancer? □ Yes □ No If Yes, at what age?</td>
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<tr>
<td>B. Current age_____ Did she ever have □ breast or □ ovarian cancer? □ Yes □ No If Yes, at what age?</td>
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<td></td>
</tr>
<tr>
<td>C. Current age_____ Did she ever have □ breast or □ ovarian cancer? □ Yes □ No If Yes, at what age?</td>
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<td></td>
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<tr>
<td>D. Current age_____ Did she ever have □ breast or □ ovarian cancer? □ Yes □ No If Yes, at what age?</td>
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</table>

**Maternal (Mother’s) Family History**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
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<tr>
<td>17) How old is your mother currently? _____ If deceased, age at time of death _____ Adopted/Unknown</td>
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<tr>
<td>Did she ever have □ breast or □ ovarian cancer? □ Yes □ No If Yes, at what age?</td>
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</table>
Maternal (Mother’s) Family History continued

18) How old is your mother’s mother currently? _____ If deceased, age at time of death _____ □ Adopted/Unknown Did she ever have □ breast or □ ovarian cancer? □ Yes □ No If Yes, at what age?_____

19) How many sisters does your mother have? _______________ □ Adopted/Unknown
   A. Current age_____ Did she ever have □ breast or □ ovarian cancer? □ Yes □ No If Yes, at what age? ______
   B. Current age_____ Did she ever have □ breast or □ ovarian cancer? □ Yes □ No If Yes, at what age? ______
   C. Current age_____ Did she ever have □ breast or □ ovarian cancer? □ Yes □ No If Yes, at what age? ______
   D. Current age_____ Did she ever have □ breast or □ ovarian cancer? □ Yes □ No If Yes, at what age? ______

Paternal (Father’s) Family History

20) How old is your father’s mother currently? _____ If deceased, age at time of death _____ □ Adopted/Unknown Did she ever have □ breast or □ ovarian cancer? □ Yes □ No If Yes, at what age?______

21) How many sisters does your father have? _______________ □ Adopted/Unknown
   A. Current age______ Did she ever have □ breast or □ ovarian cancer? □ Yes □ No If Yes, at what age? ______
   B. Current age______ Did she ever have □ breast or □ ovarian cancer? □ Yes □ No If Yes, at what age? ______
   C. Current age______ Did she ever have □ breast or □ ovarian cancer? □ Yes □ No If Yes, at what age? ______
   D. Current age______ Did she ever have □ breast or □ ovarian cancer? □ Yes □ No If Yes, at what age? ______

22) List any other relatives who have had breast cancer, ovarian cancer or pancreatic cancer. This includes male relatives, including your father.

<table>
<thead>
<tr>
<th>Relationship</th>
<th>Breast</th>
<th>Ovarian</th>
<th>Pancreatic</th>
<th>Age at Diagnosis</th>
<th>Related by Mom or Dad</th>
</tr>
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</table>

If your reported history shows an increased lifetime risk for breast cancer, or that an increased cancer risk may run in your family, we will contact you to offer an appointment with the Novant Health Cancer Prevention and Wellness Clinic. This appointment may include genetic counseling, additional breast cancer screening and/or breast cancer risk management suggestions.

If you do not wish to be notified, if you have an increased lifetime risk of breast cancer or if your family history indicates that increased cancer risk may run in your family, please check here: □

If you elect not to be contacted, we will retain the form in our records, but your risk will not be calculated or communicated to you or to your referring provider.

Feel free to contact us with any questions at 336-718-8528 or 336-397-6626.

Patient’s Signature ______________________ Date/Time __________________________

Signature of Authorized Person ______________________ Date/Time __________________________ Relationship to Patient __________________________

If limited English proficient or hearing impaired, offer interpreter at no additional cost:

□ Interpreter Accepted ______________________ □ Interpreter Refused

(Name/Number of Person/Services Chosen/Used) __________________________