NEXTGEN M.D.

6306 Gulfton St, Houston, TX 77081 • 281-888-5124 • info@nextgenscans.com

Patient Information

First Name:	
Middle Name:	
Last Name:	
Address:	
Date:	Age:
Mobile Number:	Email Address:
Referring Physician:	
Address of Provider:	
Have you had a mammogram in the past? ○ Yes ○ No	
Facility:	Date of last mammogram:

Have you had breast cancer? Y or N - if yes is it Right/Left/Both? Age?

Have the following family members had Breast Cancer? (Mother;Sister;Daughter;Aunt (M/P) Cousin (M/P))

Have you ever been diagnosed with any OTHER type of cancer? Y or N

Have you ever been diagnosed with any OTHER type of cancer? Y or N

Have you had breast biopsy or surgery? Y or N - If Yes is it Right/Left/Both? Age?

Patient Information

If your answered yes, please explain following descriptions: Cyst Aspiration (RT/LT/BOTH; Date RIGHT or Date LEFT) Surgical Biopsy (RT/LT/BOTH; Date RIGHT or Date LEFT) Needle Biopsy (RT/LT/BOTH; Date RIGHT or Date LEFT) Mastectomy (RT/LT/BOTH; Date RIGHT or Date LEFT) Lumpectomy (RT/LT/BOTH; Date RIGHT or Date LEFT) Radiation Therapy (RT/LT/BOTH; Date RIGHT or Date LEFT) Chemotherapy (RT/LT/BOTH; Date RIGHT or Date LEFT) Reconstruction (RT/LT/BOTH; Date RIGHT or Date LEFT) Breast Reduction (RT/LT/BOTH; Date RIGHT or Date LEFT) Implants (RT/LT/BOTH; Date RIGHT or Date LEFT)

Are you having problems with your breasts at this time? ○ Yes ○ No
If Yes, how long?:

Please explain following descriptions Pain (RT/LT/BOTH) Discharge (RT/LT/BOTH and Color) Lump (RT/LT/BOTH)

Date of last menstrual period:	Age at first menstruation:
Are you taking birth control?: ○ Yes ○ No	
If Yes, how long?:	
Number of children birthed:	Number of children breastfed:
Your age at first full-term pregnancy:	Age of menopause:
Age of hysterectomy:	Age of ovaries removed:
Are you taking Hormone Replacement Therapy?: ○ Yes ○ No	
If yes, how long?	

○ I authorize release of information, films and copies pertinent to my medical history and for follow-up of any suspicious findings.

Patient Signature:	Date:

Mammography Disclosure and Consent

You have the right, as a patient, to be informed about any diagnostic procedure that might involve even though minimal, any risks or complications. This disclosure is not meant to frighten or alarm you; it is simply an effort to make you better informed.
X-ray examination of the breast (mammography) is the most accurate method of detecting breast cancer. You should understand, however, that a mammogram is not 100% effective in detecting all breast cancers. Some cancers may be seen on the x-ray study and cannot be felt on physical examination. Other cancers can be felt on physical examination, but cannot be seen on the x-ray study. It is estimated that as many as 10% of cancers cannot be detected by mammograms in certain types of breasts. A negative or normal mammogram does not completely exclude the possibility of breast cancer. Additional views of your breast may be requested by the Radiologist. We may call you if this is necessary. It does not mean that your mammogram is abnormal. If you have not had a recent breast examination by a health professional prior to the mammogram, you must contact your doctor for a breast examination. Please remember to perform your monthly breast self-examination and notify your doctor of any changes, thickening, or lumps that you might encounter.
Compression of the breast is necessary to obtain the best possible views of the inside of your breasts with the least amount of radiation. You might be wondering why such vigorous compression is necessary. This kind of compression, while briefly uncomfortable, is better for you in the long run. It helps us to take much clearer x-rays of your breast with much less radiation. It's important for you to realize that: compression isn't dangerous; it doesn't damage breast tissue in any way and compression produces no long-term discomfort.

◯ Initial

The presence of an implant poses a special situation for mammographic technique and interpretation since a portion of the breast tissue may be obscured by the implants. In addition, implants are subject to complications such as the possibility of rupture, leakage, or displacement during compression. Even though these complications are not common, you as a patient need to know they can occur. Please indicate.

◯ I DO NOT have breast implants ◯ I DO have breast implants

Radiation can potentially be harmful to a developing fetus. If there is any possibility you are pregnant, this exam must be discussed with your physician and possibly rescheduled. Please indicate:

◯ I AM NOT pregnant ◯ I COULD possibly be pregnant

◯ I certify that I have received and read this information prior to my mammographic exam and that I understand its contents. I ACKNOWLEDGE THAT I HAVE READ THE FOREGOING CONSENT AND RELEASE, AND I GIVE MY CONSENT. THIS STATEMENT OF CONSENT AND RELEASE IS SIGNED OF MY OWN FREE WILL. I understand that it is my responsibility to contact my physician for results. I also authorize my physician to release information to Pink Ribbon Women's Center pertaining to my mammogram. This information is required to maintain accreditation.

Patient Signature :	Age:	
Allegergies: Y or N:	Surgery: Y or N (If Y please explain):	
Pregnant/Breastfeeding: Y or N:		
Pacemaker/Metal /Implants/Pain Pumps/Neurostimulator/Stents::		
Does PT have an implant card? Y or N:	Height:	Weight (lbs):

Visitor Screening Questionnaire

Within the past 14 days, I have traveled to a location where COVID-19 has been diagnosed or suspected: Y or N

Within the past 14 days, I have been in close contact with persons who have traveled to a location where COVID-19 has been diagnosed or suspected: Y or N

Within the past 14 days, I have been sick with a cold or flu: Y or N

Within the past 7 days, I have had a fever: Y or N

Within the last 7 days, I have had nausea and vomiting and/or loss of taste and /or smell: Y or N

Within the last 7 days, I have had diarrhea: Y or N

I now have symptoms of a cold or flu: Y or N

I now have a fever: Y or N

Within the past 14 days, I have been around people who have been or are sick with colds or flu: Y or N

I have been nauseated or have vomited or had diarrhea within the past week: Y or N

I have received the COVID-19 Vaccination: Y or N - if yes, please indicate which arm.

Identification Card: Please upload your picture ID card.

Please review to ensure the details are correct before completion.