Doctor/Clinic_____
Address_____
Phone_____**Fax.** _____

MAMMOGRAPHY SCREENING QUESTIONNAIRE

Please complete the following questions and return with the enclosed consent/release form to our office. ***PLEASE PRINT***.

FIRST_____LAST_____

ADDRESS _____

CITY_____STATE _____ZIP_____PHONE:_____

EMAIL_____

Birth date: _____
What best describes your ethnic background?
White☐Black☐Hispanic☐Asian☐Other_____

1. Do you live in Kern County? Yes☐ No ☐
2. Are you employed? Yes☐ No☐
   If so, where?_____
   Address_____Phone#_____
3. Monthly household income? _____
   How many family members in household? _____
4. Do you have insurance? (Including Medi-Cal or Medicare) Yes☐ No☐
5. Are you currently having any breast problems? Yes_____ No_____
6. Reason for screening? Family History____Sore breast____Lump____Other____
   Explain:_____
7. Breast to be screened? Left_____Right_____
8. Are you pregnant? Yes☐ No☐
9. Have you ever had a: Mastectomy? _____ Biopsy? _____ Lumpectomy? _____
   Breast Implants? ____ Breast Reduction? _____ Radiation to the Breast?_____
10. Have you ever had a mammogram before? Yes☐No☐
    If so, Date_____
    Where_____
    Results_____
11. What is the name of your Physician_____
    Address_____Phone_____
12. Where did you hear about "Links for Life"? Health Fair_____ Friend_____
    Doctor or Clinic Office_____ Radio_____ Television_____ Other _____

Return Completed Form to: **Links for Life**
5301 Office Park Drive, Suite 370
Bakersfield, CA 93309
(661) 322-5601 - Fax (661) 322-5655

CHECK ONE
☐MAMMO
☐ULTRASOUND

INFORMED CONSENT/RELEASE FORM

I understand that mammography is an X-ray examination of the breast (two X-rays are made of each breast). I'm participating in this organizations sponsored project because I want to check the health of my breasts.

I further understand that having a mammogram is only part of a complete breast screening examination. Monthly self-breast examinations are essential, since both may detect abnormalities.

I'm not pregnant or breast-feeding, nor do I have silicone implants. I also authorize the facility to release the radiologist's interpretation and a report to the physician designated below. I understand that if my screening mammogram is abnormal, I will require evaluation by a physician and am responsible for arranging an appointment.

Finally, I understand that Links for Life, which is sponsoring this program, had no participation in/nor control over the testing or the results of the test or examination. Therefore, I release the Links for Life from any liability arising from the screening or from any failure to report the results.

_____

Name Home Phone Work Phone

_____

Address

_____

Email

_____

Signature Date

PLEASE SEND MY MAMMOGRAPHY RESULTS TO:

_____

Physician's Name Office Phone Number

_____

Address City, State Zip

Sent By:_____ Phone No._____

Links for Life
5301 Office Park Drive, Suite 370, Bakersfield, CA. 93309
(661) 322-5601 Fax (661) 322-5655 or (888) 244-LINK