Clinic/ Doctor Name:
____
Address:___________________________________
Tel. _______________ 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.

____

Patient's Name Phone Number

____

Address

____

Email

____

Signature Date

PLEASE FAX MY APPROVAL TO:

____

Physician's Name Fax Number

____

Submitted by Phone No.

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