

# RADIOLOGY

Associates of Regina

X-Ray • Ultrasound • Mammography • Fluoroscopy • CT

6 - 2727 Parliament Avenue • Regina, SK • S4S 6X5

Phone: 306-779-1500 • Fax: 306-522-4311

## MAMMOGRAPHY

## BREAST ULTRASOUND

Radiology Associates is a scent free workplace. Please refrain from wearing perfumes, deodorants or powders on the day of your appointment.

APPOINTMENT DATE: ..... TIME: .....  
*(please call to confirm appointment)*

NAME ..... M  F  D.O.B. DD / MM / YY

ADDRESS .....

S.H.S.P. .... PHONE# .....

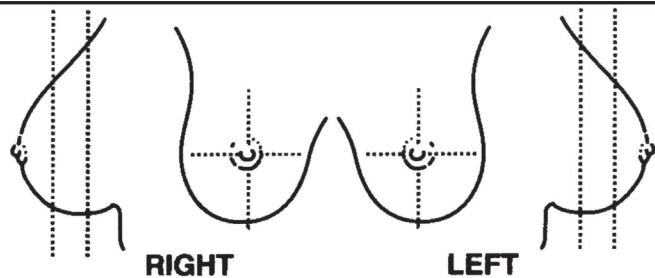
**REASON FOR EXAMINATION: (history and clinical please)** .....

.....  
.....  
.....

- |     |     |                    |     |     |                      |
|-----|-----|--------------------|-----|-----|----------------------|
| Rt  | Lt  |                    | Rt  | Lt  |                      |
| ___ | ___ | PALPABLE LUMP      | ___ | ___ | NIPPLE DISCHARGE     |
| ___ | ___ | THICKENING         | ___ | ___ | ROUTINE HEALTH CHECK |
| ___ | ___ | NIPPLE ABNORMALITY | ___ | ___ | DIFFUSE NODULARITY   |
| ___ | ___ | INFLAMMATION       | ___ | ___ | AXILLARY ADENOPATHY  |
| ___ | ___ | SKIN CHANGES       | ___ | ___ | FOLLOW UP            |
| ___ | ___ | PAIN OR TENDERNESS | ___ | ___ | OTHER / (SPECIFY)    |

Family History or Breast Cancer:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who: _____	Age at Dx: _____
Hormone Replacement Therapy:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Length of Time: _____	
Previous Mammogram/Ultrasound:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pasqua <input type="checkbox"/> Screening <input type="checkbox"/> Rad Assoc.		
	<input type="checkbox"/> Other: _____		
Previous Surgery:	<input type="checkbox"/> Yes <input type="checkbox"/> No	When: _____	
Implants:	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Date of Last Clinical Exam:	_____ day / month / year		

PLEASE INDICATE SIZE AND LOCATION OF LUMPS, SITE OF BIOPSY, SCARS, ETC.



CLINIC

DR ..... (PLEASE PRINT) .....

DOCTOR'S SIGNATURE ..... DATE .....

COPY TO .....

Drs. Adams, Jeon, Patel, Kapoor, Le, Gourgaris

