Barnabas Health
Ambulatory Care Center | RWJBarnabas HEALTH

BREAST CENTER—MALE PATIENTS

To be completed by the patient

Note: if there is deodorant or powder on your breast or underarms, please wash it off before you have the mammogram. Ask the technologist for help if you need it.

NAME_____ DATE OF BIRTH_____AGE _____

WOULD YOU LIKE YOUR RESULTS SENT VIA E-MAIL? ☐ YES ☐ NO

If yes, please provide us with your e-mail address: _____

REFERRING MD_____ TODAY'S DATE_____

YOUR PRIMARY LANGUAGE _____

1. Have you had a mammogram before? ☐ YES ☐ NO

   Where and When?_____

2. Reason for mammogram_____

   (Lump, discharge, retraction, thickening, pain)

3. Have you or any blood relative had breast cancer? ☐ YES ☐ NO

4. Are you taking any medication? ☐ YES ☐ NO

   Which type?_____How long?_____

5. Have you had surgery on your breast? ☐ YES ☐ NO

ALLERGIES ☐ None

LATEX _____ REACTION _____

MEDICATION _____ REACTION _____

FOOD _____ REACTION _____

OTHER _____ REACTION _____

Patient's Signature_____

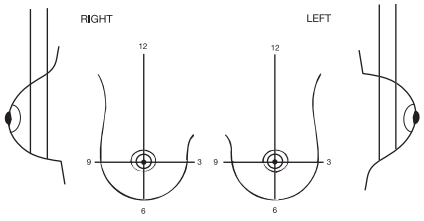
TO BE COMPLETED BY THE TECHNOLOGIST

☐ Breast surface (moles, keloids)

☐ Nipples – Inverted? Discharge? How long?_____

☐ Breast size discrepancy Which?_____

☐ Implants?_____



Comment_____