

# 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  D.O.B. .... / ... / ...  
F  DD MM YY

ADDRESS .....

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

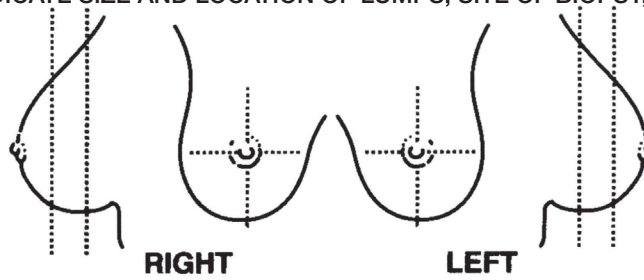
### REASON FOR EXAMINATION: (history and clinical please)

.....  
.....

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: _____	
Date of Last Clinical Exam:	_____		

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



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

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

COPY TO .....

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

