

breast biopsy _____

BREAST SCREENING INTAKE FORM

Today's Date: ____/___/

SECTION A: PERSONAL INFORMATION (PLEASE FILL IN ALL	. SPACES TO QUALIFY FOR PROGRAM
Name:	Date of Birth://
Home Address (Street, City, State, Zip):	
Phone: Email:	
CIRCLE TYPE) HOME MOBILE WORK FAMILY FRIEND	
Gender: Woman Man Non-binary Prefer to self-describe:	
Are you Hispanic/ Latina? No, not Hispanic/ Latina Yes, Hispan	nic/ Latina
What race best describes you? American Indian or Alaska Native	Asian Black or African American
Native Hawaiian or Other Pacific Islander White Other	
Are you currently employed? YES NO	
What type of insurance do you have?	
No insurance Public Insurance (Tenncare/Medicaid, VA, Medicare)	Private Insurance (HMO, PPO) If yes,
nsurance name:	
What is your monthly/annual household income? \$	How many individuals live in
your home?	
PECTION D. MAMMOCDAM LUCTORY	
SECTION B: MAMMOGRAM HISTORY	
Are you pregnant? YES NO	
Have you ever had a mammogram? YES NO	
f YES, when was your last mammogram?/	Where?
f You CANNOT remember the exact date, was it Within the last	2 years 2 or more years ago
Are you having any breast problems now? YES NO	
f YES, please mark all that apply	
Distinct lump in my breast In which breast: Left Right	Both
Lumpiness Left Right	Both
Discomfort, pain, or soreness Left Right	Both
Discharge from nipple Left Right	Both
Do you or someone in your family have a history of breast cancer? YES	NO UNSURE
F YES, please mark your relationship(s) to those family members and age at	diagnosis:
Mother (Age) Sister (Age) Daughter (Age	_) Grandmother (Age)
Aunt (Age) Niece (Age) Self	
lave you had any of the following surgeries? If so, When?	
lumpectomy	
mastectomy	

SECTION C. HOW CAN WE HELP YOU?

Type of Appointment Nee	ded					
Screening mammogran	n (Not currently h	naving any bre	east problems)			
Diagnostic Mammogran	n/Ultrasound (Cเ	urrently havino	g breast problems)			
Location Preference:						
West Cancer Center	Regional One	Downtown	Regional One Q	uince		
St. Francis Bartlett	St. Francis Pa	ark				
Preferred Date & Time: MC	NTH DAY	at TIME	AM	PM		
I may require assistance	e with transporta	tion so that I	can make an appoi	ntment.		
Referral Source/Location:			Refer	ring Physicia	n:	
Contact Number:						
funders who make thes will contact you via pho			•			cer Foundatior
Please fax both pages	to 901-786-61	86.				
For WCF Office Use Or (Information below in box WCF Staff	()		Contact N	lumber		
Notes						