



THUMB REGION

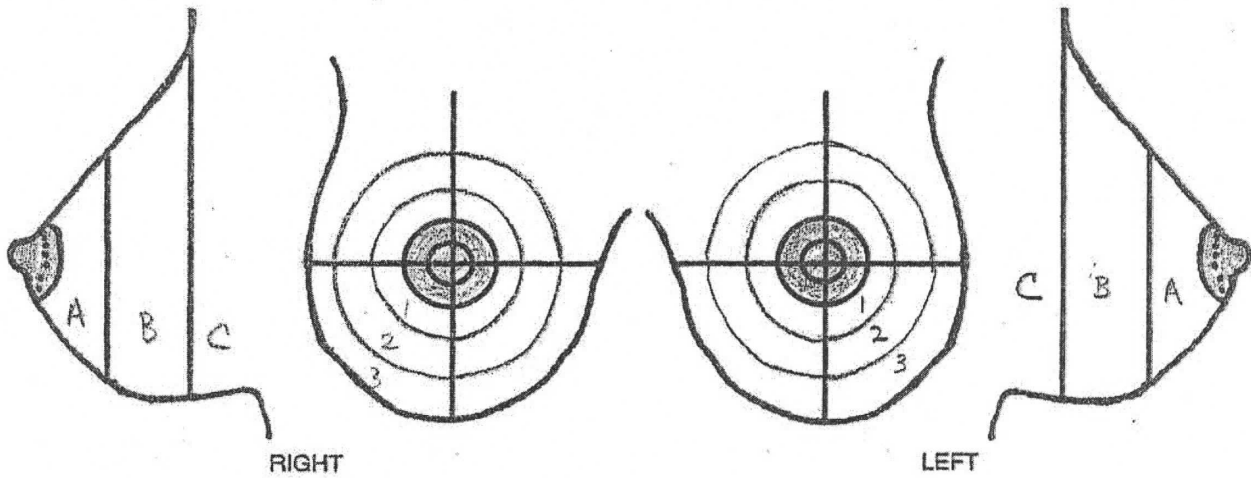
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ULTRASOUND OF BREAST

Name: _____ Age: _____ Date: _____ Doctor: _____

X-Ray #: _____ Reason for Exam: _____



RIGHT: _____

LEFT: _____

