McLaren

CARO REGION

ULTRASOUND BREAST EVALUATION

Patient Name :_____ **DATE:** _____

DOB :_____ **MR# :**_____ **REFERRING PHYSCIAN:** _____

Indication for Exam:

_____

_____Palpable Mass

_____Tenderness

_____Follow Up

Family History Breast Cancer:

_____Self _____Aunt

_____Mother _____Grandmother

_____Sister

Previous Exam:

☐ Ultrasound _____

☐ Mamms _____

Previous Surgery:

Right_____

Left_____

Comments:

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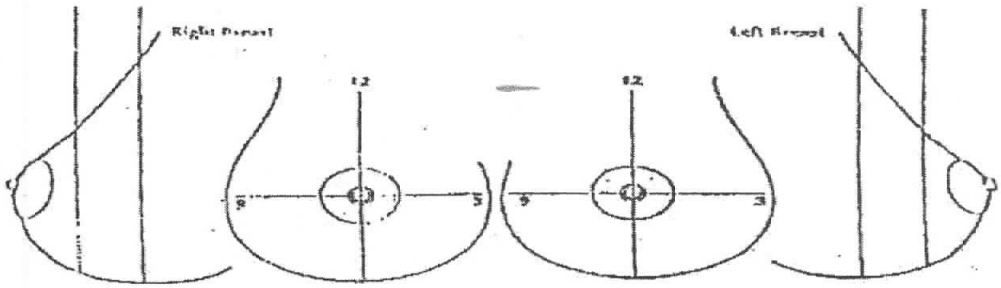

Sonographer : _____ **Date :**_____

FORM: US 11

NEW: 10-4-19