McLaren OAKLAND

BREAST CANCER SCREENING
Registration and Consent Form
Please Print

Name _____ Date of Birth: _____ Sex _____

Street Address _____ Telephone ( ) _____

City _____ State _____ Zip Code _____

Email: _____

Primary Insurance: _____ Contract #: _____ Group #: _____

Secondary Insurance: _____ Contract #: _____ Group #: _____

Do you have a personal physician? ☐ Yes ☐ No If yes, please list:

Physician's Name _____ Telephone ( ) _____

Address _____ City _____ State _____ Zip Code _____

If no, would you like information on physicians in your area? ☐ Yes ☐ No

I hereby release McLaren Oakland, all other heath care volunteers, and any other participating organizations from any liability arising from or connected with this breast cancer screening examination. By voluntarily participating in the breast cancer screening, I recognize and accept all risks associated with it. I understand that the program will only screen for abnormalities of the breast using a manual examination. Even with this screening, the best diagnosis is obtained through a complete breast cancer examination by my doctor and a diagnostic mammogram. I understand that the findings from my examination will be reported to me with recommendations, and I am responsible for any expenses involved in following these recommendations. I also understand that this is a diagnostic screening and does not constitute a complete breast cancer screening. Any further questions and/or concerns this screening may have prompted should be discussed with my doctor. It is understood that:

1. This screening is not as complete or as substitute for a full breast cancer examination by my own physician.
2. The responsibility for any follow up examinations to check abnormalities found during this breast cancer screening lies with me and not with any participating organizations, physicians, or health care volunteers. I am responsible for my own health.
3. I also understand the responsibility for initiating a follow up examination to confirm the results of this screening and for obtaining professional medical assistance is mine alone.
4. A total diagnostic exam for breast cancer will not be performed. Only a clinical manual breast exam will be performed today.

I HAVE READ AND UNDERSTAND THE ABOVE PARAGRAPHS.

Signature _____ Date signed _____

Witness _____ Date signed _____

***When did you last have a physical exam?**

☐ Within the last year ☐ 1-2 yrs ago ☐ 2-5 yrs ago ☐ >5 yrs ago ☐ Never ☐ Don't know

*** Medical History**

Last Clinical Breast Exam Date (MO/YR) _____ ☐ Never

Last Mammogram Exam Date (MO/YR) _____ ☐ Never

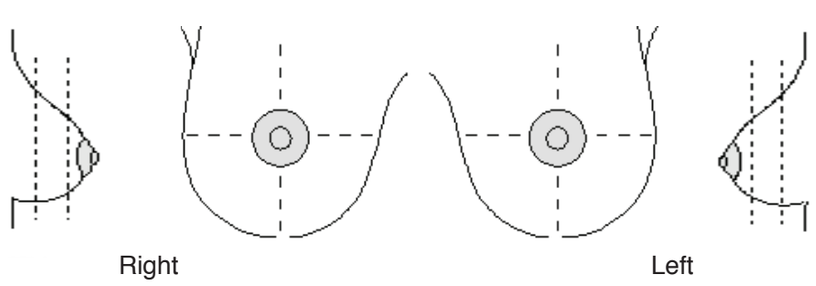
***Family History**

Have you or any of your relatives ever had breast cancer ☐ Yes ☐ No ☐ Unknown

If yes, which relative(s) _____

***Do you now have:**		Comments
-Breast lumps	☐ Yes ☐ No	
-Nipple discharge	☐ Yes ☐ No	
-Skin changes (dimpling, retraction)	☐ Yes ☐ No	
-Breast pain or tenderness	☐ Yes ☐ No	
-Have you ever had:		
-Breast cancer surgery	☐ Yes ☐ No	
-A breast biopsy	☐ Yes ☐ No	
-Breast reduction surgery	☐ Yes ☐ No	
-Other breast surgery	☐ Yes ☐ No	
-Have you ever been told you have breast disease?	☐ Yes ☐ No	
-Have you ever breast fed a baby?	☐ Yes ☐ No	
-Do you have breast implants?	☐ Yes ☐ No	

******** For Physician Use Only*******



Recommendation:

☐ Flu Clinical Exam

☐ Mammogram

☐ Other _____

Signature _____ Physician's Name _____ Time _____ Date _____