Swedish Medical Center
Mobile Mammography
First Hill Campus

Date: _____

# PATIENT REGISTRATION FORM

## PATIENT INFORMATION:

First Name _____ Last Name _____ Middle Initial _____

Street Address _____

City _____ State _____ ZIP _____

**Marital Status:**
- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widowed

**Employment Status:**
- ☐ Full-Time
- ☐ Part-Time
- ☐ Student
- ☐ Retired (Date: )

Employer's Name: _____

Work Phone Number: (_____) _____

Cell Phone: (____)_____

Date Of Birth: _____/_____/_____

Gender : ☐ Male ☐ Female

## NEXT OF KIN (EMERGENCY CONTACT)

First Name _____ Last Name _____ Middle Initial _____

Relationship to patient: _____

Work Phone (_____) _____ Home Phone (_____) _____

## PRIMARY-CARE PHYSICIAN ** REQUIRED**

Last Name _____ First Name _____ Phone # (____)_____

Address: _____ Name of Facility/Clinic: _____

**PERSON RESPONSIBLE FOR MEDICAL BILL (Please complete only if information is different from above). Or Check** ☐ SELF

First Name _____ Last Name _____

Relationship to patient: ☐ Self (same as above) ☐ Other _____

Employment Status: ☐ Full-time ☐ Part- Time ☐ Student ☐ Retired

Employer's Name: _____Work Phone Number: (____) _____

Date of Birth: _____/_____/_____

Social Security #:_____-_____-_____

updated 8/2021

Patient Label

# SWEDISH Mobile Mammography

## Mammography History Worksheet

DATE: _____

Have you been vaccinated for COVID-19? ..... ☐ No ☐ Yes Date _____ Arm R / L

Is this a routine screening mammogram? ..... ☐ Yes ☐ No

If no, what is your concern? ..... ☐ Discharge ☐ Pain ☐ Lump ☐ Other

Are you pregnant? ..... ☐ Yes ☐ No

Have you breast-fed in the last 6 months? ..... ☐ Yes ☐ No

Do you have a personal history of breast cancer? ..... ☐ Yes ☐ No

If yes: Year _____ Side _____

Type of surgery: _____

Chemo? ☐ Yes ☐ No

Radiation? ☐ Yes ☐ No

Hormonal therapy? ☐ Yes ☐ No

Have you had any non-cancer breast surgeries or biopsies?
(For example: reduction, implants, non-cancerous biopsies) ..... ☐ Yes ☐ No

If yes: Year _____ Side _____ Procedure _____

If yes: Year _____ Side _____ Procedure _____

Do you have a history of ovarian cancer or lymphoma? ..... ☐ Yes ☐ No

If yes: Year _____ Type _____

Do you have any family history of breast or ovarian cancer? ..... ☐ Yes ☐ No

If yes: Relationship _____ Type _____ Age at diagnosis _____

Relationship _____ Type _____ Age at diagnosis _____

Have you had a weight ☐ gain or ☐ loss of more than 10 pounds since your last mammogram? ☐ Yes ☐ No

Prior mammograms: ..... ☐ Yes ☐ No

Location: _____ Year: _____

*I certify that the information above is complete, correct, and contains all pertinent information for my breast study today.*

NAME: Printed _____ Signature _____

**SECTION BELOW TO BE FILLED OUT BY TECH**

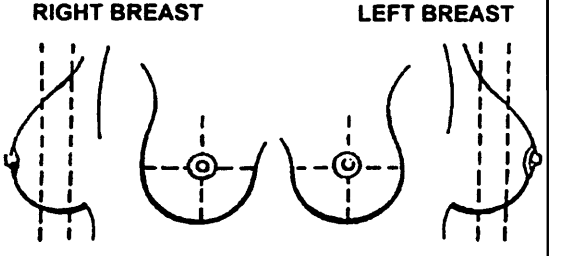
☐ Screening ☐ COACH 1 ☐ COACH 2 Account ID _____

Describe: _____

_____

_____

Tech Initials: _____

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