MOTSHUDI, BERGMAN, ROSS INCORPORATED
RADIOLOGISTS

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PRACTICE NUMBER
0586846

VAT NUMBER
4390201632

MAMMOGRAPHY HISTORY

PATIENT'S NAME: _____

REFERRING DR: _____

AGE: _____ DATE: _____

HISTORY

NUMBER OF CHILDREN: _____

DID YOU BREASTFEED? ☐ YES ☐ NO IF YES, FOR HOW LONG DID YOU BREASTFEED? _____

MENOPAUSE: ☐ PRE ☐ POST ☐ AT PRESENT

DO YOU USE ANY HORMONE TREATMENT? ☐ YES ☐ NO

IF YES, FOR HOW LONG HAVE YOU BEEN USING THIS? _____

DO YOU HAVE ANY FAMILY HISTORY OF BREAST CANCER? IF YES, PLEASE SPECIFY RELATION BELOW:

_____

_____

HAVE YOU HAD A PREVIOUS MAMMOGRAM? ☐ YES ☐ NO

REASON FOR THIS MAMMOGRAM:

_____

_____

HAVE YOU HAD ANY PREVIOUS SURGERY TO YOUR BREASTS?

_____

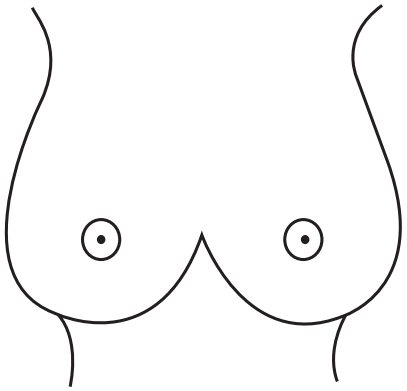
_____

PLEASE INDICATE:

MASSES ◯

SCARS |||

MOLES ⬭



INDEMNIFICATION AND CONSENT

I hereby give consent to the injection or administration of any Radiology contrast media or medication which may be necessary for the performance of my radiology examination. ☐

Notwithstanding any Medical Aid Society or other organisation's undertaking, I acknowledge personal responsibility for the payment of the account within 30 days. ☐

As a Private Patient and Patients without a valid medical aid, I agree to pay for the procedure/examination on the day. ☐

I authorise and give consent to Bergman Ross & Partners to release my medical reports, diagnostic images and referral letters for the purpose of mediating my radiology account with my medical aid as well as my referring doctor and other specialists. ☐

I hereby give consent to disclose the diagnostic codes (regarding my illness) to either my medical aid or government institution for statistical purposes, as well as 3rd parties as per conditions of the POPI (PAIA) Act of 2013. YES | NO

Please can we send you updated mammogram reminders?
Which method would you prefer? SMS ☐ Email ☐ Phone ☐

Patient Signature: _____

Patient Name: _____

Date: _____