



MRI BREAST QUESTIONNAIRE

Date: ___/___/___ Name: _____

Date of Birth: ___/___/___ Age:___ Weight: _____ Physician: _____

Reason for exam:

- Implants, Breast lump (R___ L ___), Nipple discharge, Enlarged lymph glands under arm, Known breast cancer (R___ L___), Other (Describe _____)

Previous Mammogram: ___Yes ___No Date: ___/___/___ Where?: _____

Previous Breast Ultrasound: ___Yes ___No Date: ___/___/___ Where?: _____

Previous Breast Surgery: ___Yes ___No ___Right ___Left ___Benign ___Malignant Date: _____

Or Biopsy: ___Yes ___No ___Right ___Left ___Benign ___Malignant Date: _____

Are you still menstruating? ___Yes ___No If yes, first day of last menstrual period _____

Normal cycle length? _____ (days from one period to the next)

Have you taken hormones? (Birth control or hormone replacement) ___Yes ___No

Type: _____ When did you stop? _____

Family history of breast cancer?

___Mother ___Sister ___Aunt ___Grandmother

Please check YES or NO to all the following:

YES NO

- Claustrophobia, Pacemaker, Aneurysm clips, Worked in a machine shop?, Bullets, pellets or shrapnel in body, Ear implants, Eye implant, Heart valve, coil, filter or stent in body, Neurostimulator, bone growth, or Vagul stimulator, Liver transplant recipient or waiting for liver transplant, Hearing Aid, Surgical Staples, Breast Implants (If yes, silicone ___ or saline ___), Tattoo or permanent make up, Implanted drug pump, Any other implant in body? Type: _____, Are you pregnant?, Are you breastfeeding?, Are you a diabetic? Are you on dialysis? _____ Any history of kidney disease? _____

Please show location of any breast lumps or surgery sites.

I attest that the above information is correct to the best of my knowledge. I have read and understand the entire contents of this form, and have had the opportunity to ask questions regarding the information on this form.

Patient Signature: _____ Date: _____

