BREAST MRI PATIENT QUESTIONNAIRE

DATE OF SERVICE: ________________________ PHYSICIAN: ______________________________

PATIENT NAME: _______________________________________

DOB: _________________ AGE [ ] HEIGHT [ ] WEIGHT [ ]

INDICATIONS FOR MRI (symptoms or diagnosis): ____

History of breast conditions. Do you or have you had:

- A palpable mass in your breast? (a lump that can be felt) (CIRCLE) **Yes** **No** Right Left
- Previous breast surgery? **Y** **N** Describe: _______________________________________
  Which breast? **R** **L** Where _______________________________ When _____________
  Non-malignant (benign) **Y** **N** Malignant (cancer) **Y** **N**
- Surgical clips? **R** **L** Where ____
- Injury to breast? **R** **L** Where ____
- A grandmother, mother or sister with a history of breast cancer? **Y** **N** If yes, who? ___________

Medications: Hormones **Y** **N**

Pregnant? **Y** **N** **Breast feeding?** **Y** **N**

Implants? **Y** **N** **Type?** Silicone Saline Combination

Menstrual Cycle: **Menopausal?** Y N If NO, date that last menstrual period began: _____

Other breast examinations performed:

LIST ANY THAT APPLY	FACILITY WHERE PERFORMED (Hospital, Clinic, Physicians Office)	DATE OF PROCEDURE
☐ Mammogram		
☐ CT		
☐ MRI breast		
☐ ULTRASOUND		

List all surgeries you have had in your lifetime: _______________________________________

____

Complete medical history, i.e. asthma, cancer, anemia, etc. ______________________________

____

Additional Notes:

_______________________________________ ______________

TECHNOLOGIST'S SIGNATURE DATE