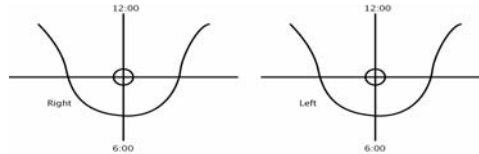


MRI QUESTIONNAIRE – BREAST

NAME: _____ D.O.B.: ____/____/____
 (Last) (First)
 AGE: _____ SEX: M / F WEIGHT: _____ HEIGHT: ____ ft. ____ in. MR # _____
 REFERRING PHYSICIAN: _____

1. Do you have any breast symptoms? Lump Y N Right Left
 Discharge Y N Right Left
 Pain Y N Right Left
2. Have you ever had a diagnosis of breast cancer? Y N Right Left
3. Does any relative have a history of breast cancer? Y N What Age? _____
 Mother Sister Grandmother Other: _____
4. Date of the first day of your last menstrual period _____
 If menopausal, please give year of last period _____
5. Do you use estrogen replacement therapy? Y N If yes, for how long? _____
6. Have you had prior breast surgery? Y N If yes, what type? _____
 Benign biopsy Right Left
 Lumpectomy Right Left
 Mastectomy Right Left
7. Have you had radiation therapy to the breast? Y N
 If yes, what side? Right Left What year? _____
8. When was your last mammogram? _____ Results? _____
9. Have you had an ultrasound of your breast?
 Y N Results? _____ Date of ultrasound _____
10. Please diagram scars or physical findings:



11. Do you have, or have you ever had, any of the following? (if yes, please circle) Y N
 PACEMAKER/DEFIBRILLATOR METAL SLIVERS IN EYES IUD
 DIABETES or KIDNEY DISEASE SHRAPNEL (bomb or bullet fragments) HEARING AID
 COCHLEAR IMPLANTS BREAST TISSUE EXPANDER BODY PIERCING
 HEART VALVE REPLACEMENT NEURO STIMULATOR PENILE IMPLANT
 TATOOS (over 20 years old) PESSARY (bladder support) ANEURYSM CLIPS
 REMOVABLE DENTAL WORK/DENTURES
 ENDOSCOPY CLIPS/INGESTED PILL CAMERA/PH BRAVO CAPSULE
 MEDICATION PATCH (birth control/nicotine/Nitroglycerine)
 ANY EXTERNAL/INTERNAL PUMPS (i.e., Insulin, chemotherapy)
12. Do you have a history of allergies? Y N If so, what kind? _____
13. Are you pregnant, or is there a possibility that you might be pregnant? Y N

I acknowledge that all the information given is accurate and thereby consent to have Magnetic Resonance Imaging (MRI) with or without an injection of contrast performed on me. I do not have a pacemaker. I have removed all hearing aids and dentures.

 Signature of Patient or Legal Guardian Date: ____/____/____ Technologist's Initials: _____

Technologist to Complete the Section Below

MR # _____ Designated Physician On-Site: _____
 Tech: _____ Supervising Physician (if different): _____
 Contrast Used: OPTIMARK / _____ mls Lot # _____