MRI QUESTIONNAIRE - BREAST

NAME: ______________________________ D.O.B.: ____/____/____ AGE: ______ SEX: M / F
(Last) (First)

WT: ___ HT: ___ ft. ___ in. REFERRING PHYSICIAN: ______________________________

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1. Do you have any breast symptoms?
   - Lump ☐ Y ☐ N ☐ Right ☐ Left
   - Discharge ☐ Y ☐ N ☐ Right ☐ Left
   - Pain ☐ Y ☐ N ☐ Right ☐ Left

2. Person history of cancer: ____Breast ___Uterine ___Ovarian ___ Colon ____Other: Please specify: ______________

2. Have you ever had a diagnosis of breast cancer? ☐ Y ☐ N ☐ Right ☐ Left What Type? ________

3. Does any relative have a history of breast cancer? ☐ Y ☐ N What Age? _____ What Type? ________
   ☐ Mother ☐ Sister ☐ Grandmother Other: ______________________________

4. Date of the first day of your last menstrual period ______________________

   If postmenopausal, please give year of last period ______________________

   Have your ovaries been removed? ☐ Y ☐ N If yes: when: ______________

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 Breast Tissue Expander ☐ Y ☐ N

7. Have you had radiation therapy to the breast? ☐ Y ☐ N If yes, what side? ☐ Right ☐ Left What year? ________

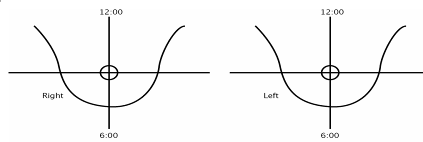
8. Have you been treated with Chemotherapy? ☐ Y ☐ N If yes, Date Started _______ Completed _______

9. Do you have Breast Implants? ☐ Y ☐ N If yes, (please circle one) Saline Silicone Do not know

10. When was your last mammogram? ______________ Results? ______________________________

11. Have you had an ultrasound of your breast? ☐ Y ☐ N Results? ___________ Date of ultrasound __________

12. Please diagram scars or physical findings:



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) performed on me. I do not have a pacemaker. I have removed all hearing aids, dentures, any external pumps and monitoring devices.

______________________________ Date: ____/____/____ Technologist Initials: ___________
Patient's Signature

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revised 5/19/18