

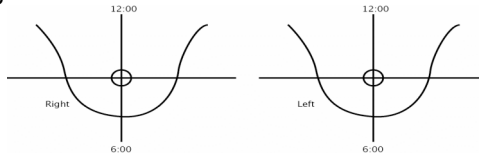


MRI Questionnaire - Breast

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

- Do you have any breast symptoms? Lump **Y N** **Right Left**
 Discharge **Y N** **Right Left**
 Pain **Y N** **Right Left**
- Have you ever had a diagnosis of breast cancer? **Y N** **Right Left**
- Does any relative have a history of breast cancer? **Y N** What Age? _____
Mother Sister Grandmother Other: _____
- Date of the first day of your last menstrual period _____
 If menopausal, please give year of last period _____
- Do you use estrogen replacement therapy? **Y N** If yes, for how long? _____
- Have you had prior breast surgery? **Y N** If yes, what type? _____
 Benign biopsy **Right Left**
 Lumpectomy **Right Left**
 Mastectomy **Right Left**
- Have you had radiation therapy to the breast? **Y N**
 If yes, what side? **Right Left** What year? _____
- When was your last mammogram? _____ Results? _____
- Have you had an ultrasound of your breast?
Y N Results? _____ Date of ultrasound _____

10. Please diagram scars or physical findings:



- 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)		
- Do you have a history of allergies? **Y N** If so, what kind? _____
- Are you pregnant, or is there a possibility that you might be pregnant? **Y N**



MRI Questionnaire - Breast

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 # _____