



# Breast MRI Questionnaire

Date: \_\_\_\_\_ Tech \_\_\_\_\_

Name: \_\_\_\_\_

Birth Date: \_\_\_/\_\_\_/\_\_\_

Primary Physician: \_\_\_\_\_ Surgeon: \_\_\_\_\_ Next appointment \_\_\_/\_\_\_/\_\_\_

**Reason for Exam:**

- |  |  |                                   |  |
|--|--|-----------------------------------|--|
| ___ screening, no problems or symptoms |  | ___ breast pain                   | <input type="checkbox"/> right <input type="checkbox"/> left |
| ___ known recent/current breast cancer | <input type="checkbox"/> right <input type="checkbox"/> left | ___ follow-up to previous MRI     |  |
| ___ breast lump or thickening          | <input type="checkbox"/> right <input type="checkbox"/> left | ___ implant problem               | <input type="checkbox"/> right <input type="checkbox"/> left |
| ___ nipple discharge/abnormality       | <input type="checkbox"/> right <input type="checkbox"/> left | ___ neoadjuvant therapy follow-up |  |
| ___ enlarged lymph glands under arm    | <input type="checkbox"/> right <input type="checkbox"/> left | ___ other: _____                  |  |

Are you currently pregnant or breast feeding?  Yes  No

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? \_\_\_/\_\_\_/\_\_\_

Do you have a family history of breast cancer?  Yes  No If yes, please check any that apply.

Mother \_\_\_\_\_ Aunt \_\_\_\_\_ Sister \_\_\_\_\_ Grandmother \_\_\_\_\_ Daughter \_\_\_\_\_

Approx. age when diagnosed: \_\_\_\_\_

Are you a breast cancer gene carrier?  Yes Date of test \_\_\_\_\_  No  Unknown/never tested

Do you have a history of Hodgkin's lymphoma?  Yes  No

If yes, describe previous treatment \_\_\_\_\_

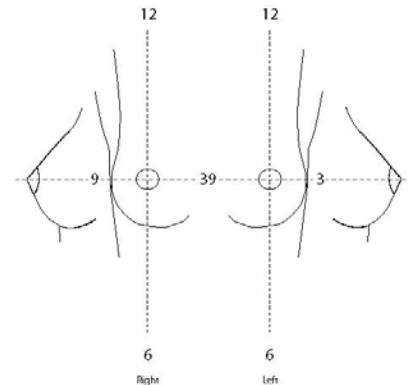
Have you had a mammogram?  Yes  No Date \_\_\_/\_\_\_/\_\_\_ Where? \_\_\_\_\_

Breast ultrasound?  Yes  No Date \_\_\_/\_\_\_/\_\_\_ Where? \_\_\_\_\_

Previous breast MRI?  Yes  No Date \_\_\_/\_\_\_/\_\_\_ Where? \_\_\_\_\_

**Have you had any of the following?**

	Left	Right	DATE and RESULTS
Cyst aspiration	<input type="checkbox"/>	<input type="checkbox"/>	_____
Needle biopsy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Surgical biopsy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lumpectomy for cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Radiation therapy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Implants.	<input type="checkbox"/>	<input type="checkbox"/>	_____
Breast reduction surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mastectomy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chemotherapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date ___/___/___



**IF THERE IS ANY LUMP OR PALPABLE ABNORMALITY,  
PLEASE INDICATE THE LOCATION ON THIS DIAGRAM.**