

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 _____

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 _____

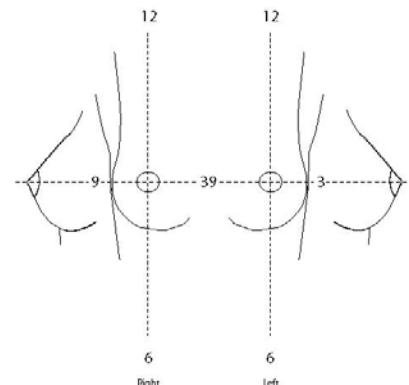
Have you had a mammogram? Yes No Date ___/___/___ Where? _____

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.**