



Breast MRI Questionnaire

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Tech: \_\_\_\_\_
Birth Date: \_\_\_/\_\_\_/\_\_\_

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

Reason for Exam:

- Screening, no problems or symptoms
Known recent/ current breast cancer
Breast lump or thickening
Nipple discharge/abnormality
Enlarged lymph glands under arm
Breast Pain
Follow-up to previous MRI
Implant Problem
Neoadjuvant therapy follow-up
Other: \_\_\_\_\_

Are you currently pregnant or breastfeeding? 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 all that apply
Mother \_\_\_ Aunt \_\_\_ Sister \_\_\_ Grandmother \_\_\_ Daughter \_\_\_
Approx. Age when diagnosed: \_\_\_\_\_

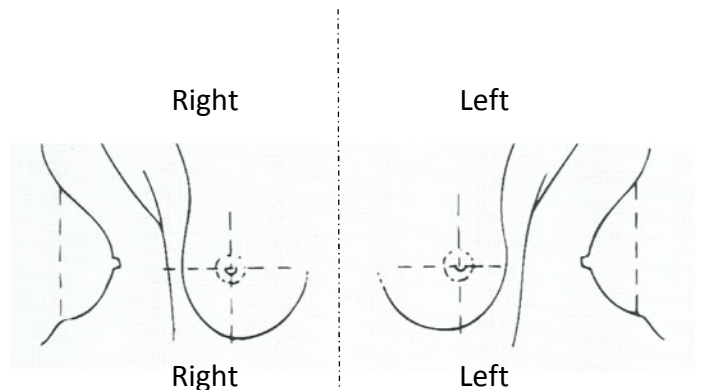
Are you a breast cancer gene carrier? Yes No Unknown/Never Tested
Date of test \_\_\_\_\_

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?

Table with 4 columns: Procedure, Left, Right, DATE and RESULTS. Rows include Cyst Aspiration, Needle Biopsy, Surgical Biopsy, Lumpectomy for cancer, Radiation Therapy, Implants, Breast Reduction Therapy, Mastectomy, and Chemotherapy.



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