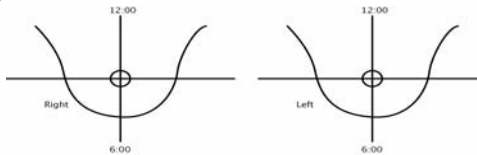


**HILLSBOROUGH RADIOLOGY ASSOCIATES, L.L.C.**  
**MRI QUESTIONNAIRE – BREAST**

NAME: \_\_\_\_\_ D.O.B.: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 (Last) (First)  
 AGE: \_\_\_\_\_ SEX: M / F WEIGHT: \_\_\_\_\_ HEIGHT: \_\_\_\_ ft. \_\_\_\_ in. MR # \_\_\_\_\_

REFERRING PHYSICIAN: \_\_\_\_\_

1. Do you have any breast symptoms? Lump  Y  N  Right  Left  
 Discharge  Y  N  Right  Left  
 Pain  Y  N  Right  Left
2. Have you ever had a diagnosis of breast cancer?  Y  N  Right  Left
3. Does any relative have a history of breast cancer?  Y  N What Age? \_\_\_\_\_  
 Mother  Sister  Grandmother Other: \_\_\_\_\_
4. Date of the first day of your last menstrual period \_\_\_\_\_  
 If menopausal, please give year of last period \_\_\_\_\_
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
7. Have you had radiation therapy to the breast?  Y  N  
 If yes, what side?  Right  Left What year? \_\_\_\_\_
8. When was your last mammogram? \_\_\_\_\_ Results? \_\_\_\_\_
9. Have you had an ultrasound of your breast?  
 Y  N Results? \_\_\_\_\_ Date of ultrasound \_\_\_\_\_
10. Please diagram scars or physical findings:



11. 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)		
12. Do you have a history of allergies?  Y  N If so, what kind? \_\_\_\_\_
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 and dentures.

\_\_\_\_\_  
 Signature of Patient or Legal Guardian Date: \_\_\_\_/\_\_\_\_/\_\_\_\_