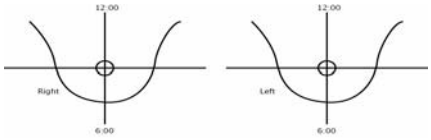
MRI QUESTIONNAIRE - BREAST

NAME: _____ **D.O.B.:** _____/_____/_____ **AGE:** _____ **SEX: M / F**
(Last) (First)

WT: ___ **HT:** ___ **ft.** ___ **in.** **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 **What Type?** _____
3. **Does any relative have a history of breast cancer?** ☐ Y ☐ N **What Age?** _____ **What Type?** _____
   ☐ Mother ☐ Sister ☐ Grandmother **Other:** _____
4. **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?** _____
6. **Have you had prior breast surgery?** ☐ Y ☐ N **If yes, what type?** _____
   ☐ Benign biopsy ☐ Right ☐ Left
   ☐ Lumpectomy ☐ Right ☐ Left
   ☐ Mastectomy ☐ Right ☐ Left **Breast Tissue Expander** ☐ Y ☐ N
7. **Have you had radiation therapy to the breast?** ☐ Y ☐ N **If yes, what side?** ☐ Right ☐ Left **What year?** _____
8. **Have you been treated with Chemotherapy?** ☐ Y ☐ N **If yes, Date Started** _____ **Completed** _____
9. **Do you have Breast Implants?** ☐ Y ☐ N **If yes, (please circle one)** **Saline** **Silicone** **Do not know**
10. **When was your last mammogram?** _____ **Results?** _____
11. **Have you had an ultrasound of your breast?** ☐ Y ☐ N **Results?** _____ **Date of ultrasound** _____
12. **Please diagram scars or physical findings:**



13. **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	MEDICATION PATCH (birth control/nicotine/Nitroglycerine)	
ENDOSCOPY CLIPS/INGESTED PILL CAMERA/PH BRAVO CAPSULE		STENTS
ANY EXTERNAL/INTERNAL PUMPS (i.e., Insulin, chemotherapy)		BRACES
		HISTORY OF EAR TUBES

14. **Do you have a history of allergies?** ☐ Y ☐ N **If so, what kind?** _____
15. **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, dentures, any external pumps and monitoring devices.

_____ **Date:** _____/_____/_____ **Technologist Initials:** _____
Patient's Signature