

Patient Name _____ DOB ___ / ___ / ___ Date ___ / ___ / ___ MRN _____

QUESTIONNAIRE: BREAST MRI

Weight: _____ Height: _____ Bra Size: _____ ERI X-ray # _____

PATIENT HISTORY

Breast Biopsy Left Right Quadrant/Location _____
 Surgical Needle Date _____
 Results _____

Breast Imaging

Mammogram

MRI should not be done without a current mammogram (within the last 3 months)

Location (Facility) _____ Date _____

Ultrasound

Location (Facility) _____ Date _____

Other (exam) _____ Date _____ Result _____

Menstrual History

Date of last period _____ Days in one cycle _____

Hormone Treatment _____ Birth Control _____ Fertility Drugs _____

Breast Cancer

Left Right Date Diagnosed _____

Treatment _____

Family History of Breast Cancer? Yes No

If Yes: Mother _____ Age _____

Sister _____ Age _____

Grandmother _____ Age _____

Maternal Aunt _____ Age _____

Have you had breast implants? (If yes, please circle) Silicone Saline

What is the specific information to be gained by MRI? _____

Patient Signature _____ Technologists _____