EASTERN RADIOLOGISTS
GREENVILLE MRI

2101 W Arlington Blvd, Suite 110, Greenville, NC 27834
Mon–Fri 7am–9pm • Sat / Sun 8am–8pm
252.752.5000 | easternrad.com

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 ______________________________