MRI QUESTIONNAIRE - BREAST

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

WT: ___ HT: ___ ft. ___ in. REFERRING PHYSICIAN: _____

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1. Do you have any breast symptoms?
   Lump ☐ Y ☐ N ☐ Right ☐ Left
   Discharge ☐ Y ☐ N ☐ Right ☐ Left
   Pain ☐ Y ☐ N ☐ Right ☐ Left

2. Person history of cancer: ___Breast ___Uterine ___Ovarian ___ Colon ___Other: Please specify: _____

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 postmenopausal, please give year of last period _____

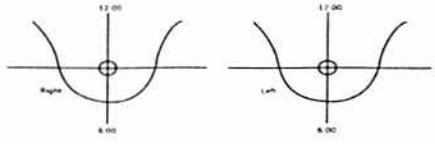
   Have your ovaries been removed? ☐ Y ☐ N If yes: when: _____

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 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. Have you taken a drug call AVASTIN? ☐ Yes ☐ No *If Yes, when was the last time your received the drug AVASTIN?* _____

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. 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