



DEDICATED BREAST MRI PATIENT HISTORY FORM

PATIENT NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_
PHYSICIAN: \_\_\_\_\_

IS THIS YOUR FIRST BREAST MRI?: YES \_\_\_\_\_ NO \_\_\_\_\_

IF NOT, WHEN AND WHERE WAS YOUR PRIOR MRI DONE? \_\_\_\_\_

WHERE AND WHEN DID YOU HAVE ANY PRIOR MAMMOGRAMS OR BREAST ULTRASOUNDS? \_\_\_\_\_

WHY ARE YOU HAVING A BREAST MRI TODAY? \_\_\_\_\_

ANY KNOWN ALLERGIES? \_\_\_\_\_

PLEASE CHECK OFF ANY OF THE FOLLOWING BREAST SYMPTOMS THAT YOU CURRENTLY HAVE:

- LUMP OR THICKNESS RIGHT \_\_\_\_\_ LEFT \_\_\_\_\_
INFECTION/INFLAMMATION RIGHT \_\_\_\_\_ LEFT \_\_\_\_\_
PAIN OR TENDERNESS RIGHT \_\_\_\_\_ LEFT \_\_\_\_\_
RECENT BREAST INJURY RIGHT \_\_\_\_\_ LEFT \_\_\_\_\_
NIPPLE DISCHARGE RIGHT \_\_\_\_\_ LEFT \_\_\_\_\_
DISCHARGE COLOR \_\_\_\_\_
NIPPLE ABNORMALITY RIGHT \_\_\_\_\_ LEFT \_\_\_\_\_
LARGE LYMPH NODES RIGHT \_\_\_\_\_ LEFT \_\_\_\_\_
OTHER \_\_\_\_\_

HAVE YOU HAD BREAST CANCER? \_\_\_\_\_ IF YES, WHICH BREAST? \_\_\_\_\_

HAVE YOU HAD ANY OTHER TYPE OF CANCER? \_\_\_\_\_ IF YES, WHAT KIND? \_\_\_\_\_

HAS ANYONE IN YOUR FAMILY HAD BREAST CANCER OR OVARIAN CANCER?

IF YES, WHO HAD BREAST CANCER? HOW ARE THEY RELATED TO YOU AND AT WHAT AGE WERE THEY FIRST DIAGNOSED? \_\_\_\_\_

PLEASE CHECK OFF ANY OF THE FOLLOWING PROCEDURES THAT YOU HAVE HAD:

- IMPLANTS RIGHT \_\_\_\_\_ LEFT \_\_\_\_\_ TYPE: SALINE \_\_\_\_\_ SILICONE \_\_\_\_\_ DON'T KNOW \_\_\_\_\_
CYST ASPIRATION RIGHT \_\_\_\_\_ LEFT \_\_\_\_\_
NEEDLE BIOPSY RIGHT \_\_\_\_\_ LEFT \_\_\_\_\_
SURGICAL BIOPSY RIGHT \_\_\_\_\_ LEFT \_\_\_\_\_
RESULTS \_\_\_\_\_
BREAST REDUCTION RIGHT \_\_\_\_\_ LEFT \_\_\_\_\_
LUMPECTOMY (CANCER) RIGHT \_\_\_\_\_ LEFT \_\_\_\_\_
MASTECTOMY (CANCER) RIGHT \_\_\_\_\_ LEFT \_\_\_\_\_
RECONSTRUCTION RIGHT \_\_\_\_\_ LEFT \_\_\_\_\_

HAVE YOU HAD CHEMOTHERAPY? \_\_\_\_\_ IF YES, WHEN? \_\_\_\_\_

HAVE YOU HAD RADIATION THERAPY? \_\_\_\_\_ IF YES, WHEN? \_\_\_\_\_

HAVE YOU TAKEN TAMOXIFEN OR EVISTA \_\_\_\_\_

GYNECOLOGICAL HISTORY:

ARE YOU PREGNANT? \_\_\_\_\_ FIRST DAY OF LAST MENSTRUAL PERIOD: \_\_\_\_\_

ARE YOU BREAST FEEDING? \_\_\_\_\_

ARE YOU TAKING BIRTH CONTROL PILLS? \_\_\_\_\_

HAVE YOU HAD A HYSTERECTOMY? \_\_\_\_\_ AGE: \_\_\_\_\_ WERE YOUR OVARIES REMOVED? \_\_\_\_\_

ARE YOU CURRENTLY TAKING HORMONES? \_\_\_\_\_

HAVE YOU EVER TAKEN HORMONES? \_\_\_\_\_

HOW MANY TIMES HAVE YOU BEEN PREGNANT? \_\_\_\_\_

AGE WHEN YOU DELIVERED YOUR FIRST LIVE BIRTH? \_\_\_\_\_

I ATTEST THAT THE INFORMATION I HAVE PROVIDED ON THIS FORM IS TRUE TO THE BEST OF MY KNOWLEDGE.

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_ TECH \_\_\_\_\_