MRI Questionnaire (Breast Only)

Name:_____ Date of Birth:_____ Date: _____

Referring Doctor:_____ Weight:_____ Height:_____

Have you ever been a metal worker, machinist, cut or grind any metal?	**YES**	**NO**
Have you ever had a penetrating eye injury?	**YES**	**NO**
Do you wear a transdermal patch (nicotine or pain patch)?	**YES**	**NO**
Are you wearing "magneto" or magnetic gel-nail polish?	**YES**	**NO**

Prior Breast MRI?	**YES**	**NO**	If yes, when and where?_____
Prior Mammograms?	**YES**	**NO**	If yes, when and where?_____
Prior Ultrasound?	**YES**	**NO**	If yes, when and where?_____

Do you have:

Pacemaker	**YES**	**NO**	
Cosmetic Tattoos	**YES**	**NO**	
Cerebral Aneurysm Clips	**YES**	**NO**	Date Implanted: _____
Abdominal Aneurysm	**YES**	**NO**	Date Implanted: _____
Pacemaker	**YES**	**NO**	Date Implanted: _____
Defibrillator	**YES**	**NO**	Date Implanted: _____
Tissue Expander	**YES**	**NO**	Date Implanted: _____
IUD	**YES**	**NO**	Date Implanted: _____
Shrapnel (bullets)	**YES**	**NO**	Date Implanted: _____
Stents	**YES**	**NO**	Date Implanted: _____
Any Metal Implant	**YES**	**NO**	Date Implanted: _____
Heart Valve	**YES**	**NO**	Date Implanted: _____
Neuro Stimulator	**YES**	**NO**	Date Implanted: _____
Hearing Aid	**YES**	**NO**	Date Implanted: _____
Cochlear Ear Implant	**YES**	**NO**	Date Implanted: _____
Shunt	**YES**	**NO**	Date Implanted: _____
Portacath	**YES**	**NO**	Date Implanted: _____
Any other metals	**YES**	**NO**	Date Implanted: _____
Greenfield Filter (IVC)	**YES**	**NO**	Date Implanted: _____
Renal Failure/Disease	**YES**	**NO**	

**Is this test related to a motor vehicle accident or slip and fall that is currently under litigation or may be in litigation in the future?	**YES**	**NO**
**Is this test related to a workman's compensation claim?	**YES**	**NO**

MRI Questionnaire (Breast Only)

Have you been diagnosed with breast cancer? **Yes** **No**

If yes, which side *(circle)*: **Right** **Left** **Both** When: _____ Type: _____

Did you receive treatment? **Yes** **No** If yes, what *(circle)* **Radiation** **Chemotherapy**

Have you been diagnosed with Ovarian Cancer? **Yes** **No** If yes, age at diagnosis: _____

Have you had your ovaries or uterus removed? **Yes** **No** If yes, age at removal: _____

Have you ever had a child? **Yes** **No** Age of 1st birth _____ Number of Pregnancies: _____

If you have gone through menopause, age at onset _____ Last Menstrual Period: _____

Age at first menstrual cycle? _____

How many benign (not cancer) breast biopsies have you had? _____

Any previous breast surgery and/or implants? **Yes** **No** Which Breast: **Right** **Left** **Both**

What: _____ When: _____ Where: _____

Family History of Breast Cancer: **(*P- Paternal M- Maternal)*

Mom	**Yes**	**No**	*(P / M)*	Age Diagnosed: _____	Current Age or Age at Death: _____
Daughter	**Yes**	**No**	*(P / M)*	Age Diagnosed: _____	Current Age or Age at Death: _____
Aunt	**Yes**	**No**	*(P / M)*	Age Diagnosed: _____	Current Age or Age at Death: _____
Sister	**Yes**	**No**	*(P / M)*	Age Diagnosed: _____	Current Age or Age at Death: _____
Grandmother	**Yes**	**No**	*(P / M)*	Age Diagnosed: _____	Current Age or Age at Death: _____
Cousin	**Yes**	**No**	*(P / M)*	Age Diagnosed: _____	Current Age or Age at Death: _____

BRCA Gene: Unknown Tested Normal BRCA1+ BRCA2+

Do you have any moles or scars on breast? **Yes** **No**

Are you taking hormonal replacement (estrogens, progesterone's, Evista) or BCP? **Yes** **No**

If yes, age started: _____

Do you regularly practice monthly breast self-exam? **Yes** **No**

Patient Signature: _____ **Date:** _____