Breast MRI Questionnaire

Name: _____ DOB: _____ Date: _____

Referring Doctor: _____ Weight: _____lbs. Height: ____ft _____in

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**

Breast MRI Questionnaire

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 at 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: **Left** **Right** **Bilateral**

What: _____ When: _____ Where: _____

Family History of Breast Cancer: ***Please circle to indicate either P – Paternal or 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 your breasts? **YES** **NO**

Are you taking hormonal replacement (estrogens, progesterones, Evista) or BCP? **YES** **NO**

If yes, age started: _____

Do you regularly practice monthly breast self-exams? **YES** **NO**

Patient or Guardian Signature: _____ Date: _____