



Breast MRI Questionnaire



Date _____ Tech _____

Name: _____

Birth Date: ___/___/___

Primary Physician: _____ Surgeon: _____ Next appointment ___/___/___

Reason for Exam:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> screening, no problems or symptoms | <input type="checkbox"/> right <input type="checkbox"/> left | <input type="checkbox"/> breast pain | <input type="checkbox"/> right <input type="checkbox"/> left |
| <input type="checkbox"/> known recent/current breast cancer | <input type="checkbox"/> right <input type="checkbox"/> left | <input type="checkbox"/> follow-up to previous MRI | |
| <input type="checkbox"/> breast lump or thickening | <input type="checkbox"/> right <input type="checkbox"/> left | <input type="checkbox"/> implant problem | <input type="checkbox"/> right <input type="checkbox"/> left |
| <input type="checkbox"/> nipple discharge/abnormality | <input type="checkbox"/> right <input type="checkbox"/> left | <input type="checkbox"/> neoadjuvant therapy follow-up | |
| <input type="checkbox"/> enlarged lymph glands under arm | <input type="checkbox"/> right <input type="checkbox"/> left | <input type="checkbox"/> other: _____ | |

Are you currently pregnant or breast feeding? Yes No

Are you still menstruating? Yes No If yes, first day of last menstrual period ___/___/___

Normal cycle length (days from one period to the next): _____

Have you taken hormones? (birth control or hormone replacement) Yes No

Type: _____ When did you stop? ___/___/___

Do you have a family history of breast cancer? Yes No If yes, please check any that apply.

Mother _____ Aunt _____ Sister _____ Grandmother _____ Daughter _____

Are you a breast cancer gene carrier? Yes Date of test _____ No Unknown/never tested

Do you have a history of Hodgkin's lymphoma? Yes No

If yes, describe previous treatment _____

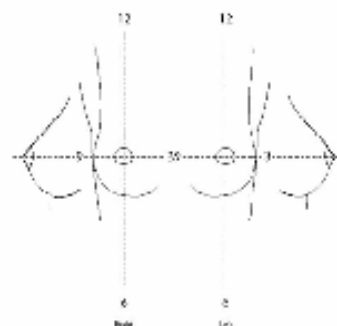
Have you had a mammogram? Yes No Date ___/___/___ Where? _____

Breast ultrasound? Yes No Date ___/___/___ Where? _____

Previous breast MRI? Yes No Date ___/___/___ Where? _____

Have you had any of the following?

	Left	Right	DATE and RESULTS
Cyst aspiration	<input type="checkbox"/>	<input type="checkbox"/>	_____
Needle biopsy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Surgical biopsy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lumpectomy for cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Radiation therapy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Implants.	<input type="checkbox"/>	<input type="checkbox"/>	_____
Breast reduction surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mastectomy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chemotherapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date ___/___/___



IF THERE IS ANY LUMP OR PALPABLE ABNORMALITY, PLEASE INDICATE THE LOCATION ON THIS DIAGRAM.