BREAST MRI SCREENING QUESTIONNAIRE

BREAST HEALTH CENTER
BREAST MAGNETIC RESONANCE IMAGING

PATIENT INFORMATION REQUEST

PLEASE PRINT

Patient Name: ______________________

Referring Drs: ______________________

____

Age: __________

Phone Number ______________________

May we leave a message: ☐ Yes ☐ No

Are you post menopausal? ☐ Yes ☐ No

If not menopausal, what was the first day of Your last period? ______________

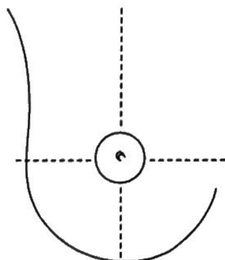
Reason for MRI exam: ______________________

Do you have a recent diagnosis of breast cancer? ☐ Yes ☐ No If yes, indicate on diagram below with a "X"

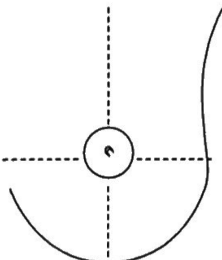
Do you have a new breast lump? ☐ Yes ☐ No If yes, indicate on diagram below with a "O"

Have you had prior surgery? Lumpectomy ☐ Yes Date: ______________ ☐ No

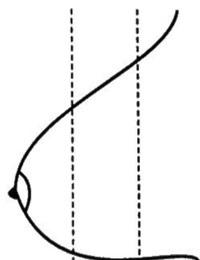
If yes, indicate on diagram below with a "–" Benign biopsy ☐ Yes ☐ No



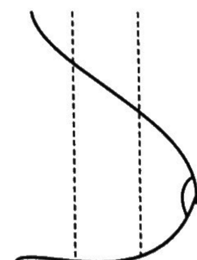
Right



Left



Right



Left

Have you had breast augmentation? ☐ Yes ☐ No ☐ Right ☐ Left

☐ Saline ☐ Silicone ☐ Both ☐ Don't know

PRIOR IMAGING HISTORY

Last Mammogram: ☐ CPMC ☐ Elsewhere-Location ______________ Date: __________

Last Breast Ultrasound ☐ CPMC ☐ Elsewhere-Location ______________ Date: __________

Last Breast MRI: ☐ CPMC ☐ Elsewhere-Location ______________ Date: __________

Family history of breast cancer? ☐ Mother Age @ diagnosis ________

☐ Sister Age @ diagnosis ________

☐ Daughter Age @ diagnosis ________

Additional Comments: ______________________