Breast MRI History Form

Date: _____

Last Name: _____ First Name: _____ MI: ____ Age: ____ Birth Date: _____

Your Address: _____
(City) (State) (Zip Code)

Your Phone Number: _____ _____
Home Work

Your Doctor's Name: _____

Have you had previous mammograms? ❑ Yes ❑ No Where? _____ When? _____

List any family history of breast cancer	Relative	at Age	Premenopausal?
	_____	_____	❑ Yes ❑ No
	_____	_____	❑ Yes ❑ No
	_____	_____	❑ Yes ❑ No

Are you taking estrogen? ❑ Yes ❑ No If yes, how long have you taken estrogen? _____

Please check the box if you have had any of the following types of breast surgery or breast cancer treatment:

❑ Biopsy: ❑ Right ❑ Left When? _____ Results of Biopsy _____

❑ Reduction: ❑ Right ❑ Left When? _____

❑ Implants: ❑ Right ❑ Left When? _____

❑ Mastectomy for breast cancer: ❑ Right ❑ Left When? _____

❑ Lumpectomy for breast cancer: ❑ Right ❑ Left When? _____

❑ Radiation for breast cancer: ❑ Right ❑ Left When? _____

❑ Chemotherapy for breast cancer: ❑ Right ❑ Left When? _____

❑ Other types of cancer _____

Are you currently having any problems with your breast(s)? ❑ Yes ❑ No If yes, explain _____

_____

Breast symptoms/signs: ❑ None

Lump: ❑ Right ❑ Left Duration? _____ Was the lump felt by you or your physician? _____

Pain: ❑ Right ❑ Left Duration? _____ ❑ Focal ❑ Diffuse

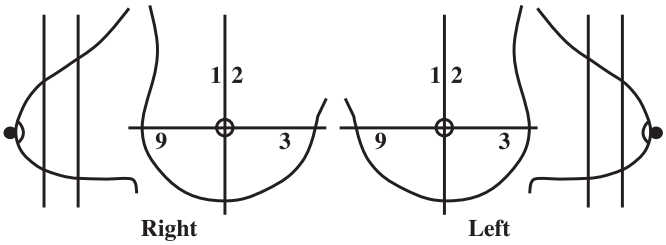
Nipple retraction: ❑ Right ❑ Left Duration? _____

Skin retraction: ❑ Right ❑ Left Duration? _____

Nipple discharge: ❑ Right ❑ Left Duration? _____ ❑ Spontaneous ❑ Only when expressed

Color of nipple discharge: _____

Please mark area of focal pain, lump or skin retraction below:



PATIENT MRI SAFETY SCREENING FORM

Name_____ Weight_____

Date of Birth_____ Last menstrual period_____ ❑ N/A

Please check any that apply:
Possibly pregnant? ❑ Yes Claustrophobic (afraid of closed in areas)? ❑ Yes
Have you **EVER** worked around metal grinding/filing or welding? ❑ Yes
Have you **EVER** had metal particles in your eyes? ❑ Yes

Please list any surgeries you have had _____

_____

Please list any known allergies to latex, tape or drugs that you have: _____

Do you have history of renal disease or dialysis? ❑ No ❑ Yes

The following items ***can*** interfere with MR imaging and ***can*** be hazardous to your safety. Please check appropriate items & notify the Technologist if you have any of the following:

_____Cardiac pacemaker	_____Hearing aids	_____Brain clips
_____Cochlear implants	_____Aortic clips	_____Shunts
_____Carotid clips	_____Joint replacements	_____Neurostimulators (Tens)
_____Harrington rod	_____Heart valve replacements	_____Bone or joint pins
_____Insulin pump	_____Prosthesis	_____Electrodes
_____Wire sutures	_____Metal mesh	_____Shrapnel
_____Metal plates	_____Dental/teeth work with magnets	_____Stents
	_____Therapeutic Magnets or screws, nails or metal rods	

_____Other (please list) _____

DO NOT ENTER THE SCANNING ROOM WITH ANY OF THE FOLLOWING ITEMS:
Hearing aids, Magnetic strip cards (credit cards, bank cards), Jewelry, Hairpins/barrettes, Glasses, Watch, Wallet/Money Clip, Pocketknife, Safety pins, Pens/pencils, Phone/pager, Keys, Coins

**** Lockers will be provided to lock patient valuables ****

I have reviewed and confirmed that the above information is complete to the best of my knowledge:

Pt. Signature_____ **Date**_____

Please turn form over for additional information

MRI Technologist has interviewed patient:_____Tech