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

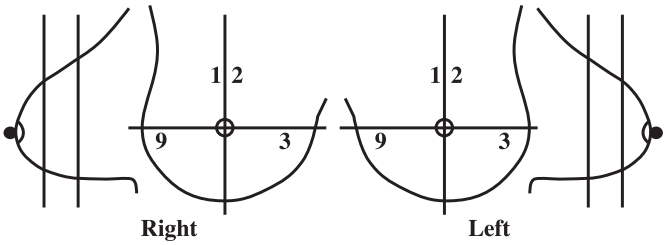
Nipple retraction: ❑ Right ❑ Left Duration? _____

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:



DIAGNOSTIC RADIOLOGY & IMAGING
we see you.

NAME:_____

DOB:_____

WEIGHT:_____ **lbs.**_____

The following items may be harmful to you during your MRI Scan or may interfere with the MRI examination. You must provide a "yes" or "no" for every item. Please indicate if you have, or have had any of the following:

*** SIGNATURE:**	**YES**	**NO**
Any type of electronic, mechanical, or magnetic implant: ear (otologic, cochlear, or other ear implant), penile, or other If yes, type: _____	☐	☐
Cardiac pacemaker, defibrillator or other cardiac implant (in place or removed)	☐	☐
Aneurysm clip	☐	☐
Artificial heart valve	☐	☐
Neurostimulator / biostimulator (e.g., spinal cord or brain stimulator) If yes, type _____	☐	☐
Any type of internal electrodes or wires	☐	☐
Hearing aid	☐	☐
Implanted drug pump (e.g., insulin, baclofen, chemotherapy, pain medicine)	☐	☐
Medication patch (e.g., nitroglycerin, nicotine)	☐	☐
Spinal fixation device (e.g., Halo Vest)	☐	☐
Spinal fusion procedure	☐	☐
Any type of coil, filter, or stent If yes, where and what type?_____	☐	☐
Any type of metal object (e.g., shrapnel, bullet, BB, metal fragment, or foreign body)	☐	☐
Bone growth / bone fusion stimulator	☐	☐
Shunt (spinal or intra-ventricular)	☐	☐
Eye surgery (e.g., eyelid springs, scleral buckle, cataracts, cornea transplant, or other eye implant)	☐	☐
Any type of surgical clip or staple	☐	☐
Any IV access port (e.g., Broviac, Port-a-Cath, Hickman, PICC line)	☐	☐
Endoscopy or Colonoscopy in the last 30 days? If yes, when? _____	☐	☐
Prosthesis (artificial limb, joint, or eye) If yes, location:_____	☐	☐
Tissue expander (e.g., breast)	☐	☐
Removable dentures, false teeth or partial plate	☐	☐
Diaphragm, IUD, pessary If yes, type: _____	☐	☐
Surgical mesh If yes, location _____	☐	☐
Body piercing, including dermal (under the skin) If yes, location _____	☐	☐
Permanent makeup (tattoos or tattooed eyeliner)	☐	☐
Radiation seeds (e.g., cancer treatment)	☐	☐
Bone / joint pins, rods, screws, nails, plates, wires, spinal fusion, etc. If yes, location:_____	☐	☐
Tracking device (such as an ankle bracelet provided by law enforcement)	☐	☐

MRNOTE

TECHNOLOGIST:_____