BREAST MRI QUESTIONNAIRE

MR# _____

☐ Female

Date of Service: _____

Patient's Name: _____

DOB: _____

Age: _____

Address: _____

_____

Home Phone: _____

Other Phone: _____

Referring Physician: _____

Are you wearing any perfume, lotion, deodorant, and/or powder? ☐ Yes ☐ No

PRIOR MAMMOGRAM? ☐ Yes ☐ No

Where? _____

When? _____

Called for? ☐ Yes ☐ No

☐ baseline
☐ routine exam

Problems: _____

Menstrual Status: Age at 1st: _____

LMP (last monthly period): _____

Uterus or Ovaries removed? ☐ Yes ☐ No

Age? _____

Any chance of pregnancy now? ☐ Yes ☐ No

Age at first live birth? _____

Breast feed? ☐ Yes ☐ No

FAMILY HISTORY OF BREAST CANCER?
☐ Yes ☐ No

☐ Mother (Age:_____)
☐ Daughter (Age:_____)
☐ Sister (Age:_____)
☐ Grandmother (Age:_____) ☐ Mother / ☐ Father
☐ Aunt (Age:_____) ☐ Mother / ☐ Father
☐ Cousin (Age:_____) ☐ Mother / ☐ Father

HAVE YOU BEEN PREVIOUSLY DIAGNOSED WITH BREAST CANCER? ☐ Yes ☐ No

☐ Left ☐ Right ☐ Both Date: _____

Treatment given:

☐ Mastectomy ☐ Lumpectomy
☐ Radiation ☐ Chemo

Have you had prior breast surgery? ☐ Yes ☐ No

Biopsy: ☐ Left ☐ Right ☐ Both Date:_____

Implants: ☐ Left ☐ Right ☐ Both Date:_____

Lumpectomy: ☐ Left ☐ Right ☐ Both Date:_____

Reduction: ☐ Left ☐ Right ☐ Both Date:_____

Cyst Removal: ☐ Left ☐ Right ☐ Both Date:_____

Do you have any moles or scars on breast?

Are you taking hormonal replacement (estrogens, progesterones, Evista) or BCP?

_____

Age started? _____

Do you regularly practice monthly breast self-exam? ☐ Yes ☐ No

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