



MRI BREAST IMAGING QUESTIONNAIRE

Patient's Name _____ Date of Birth _____ Age _____

Home Telephone _____ Cell Phone _____

Referring Physician _____ Additional Physician _____

Gender: _____ Female _____ Male

Date of last mammography: _____ Where performed? _____

Date of first day of menstrual period? _____ Any possibility of pregnancy? _____

Any pregnancies since last mammography: _____ Currently breast feeding: _____

Any weight change (>15 lbs) since last mammo: _____

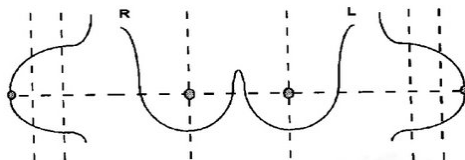
Age 1st Pregnancy: _____ Age 1st Period: _____ Age Last Period: _____

YES	NO	<u>INDICATE ANY CURRENT COMPLAINTS / SYMPTOMS:</u>		
___	___	Pain and/or soreness	RIGHT	LEFT _____
___	___	Lump (new or enlarging)	RIGHT	LEFT _____
___	___	Discharge from nipple:	RIGHT	LEFT _____
___	___	Any Complaints or Symptoms: _____		

YES	NO	<u>RISK FACTORS / MEDICAL HISTORY</u>
___	___	Family History of Breast Cancer: ___Mother ___Sister ___Daughter
		Age when diagnosed: _____
___	___	Personal History of Cancer: ___Breast ___Uterine ___Ovarian ___Colon
		___ other
___	___	Ovaries Removed: _____
___	___	Breast Surgery:
		(Please indicate which breast, age / date performed, and if benign or malignant)
		Cyst Aspiration _____
		Excisional Biopsy _____
		Lumpectomy _____
		Mastectomy _____
		Breast Reduction _____
		Radiation _____
___	___	Breast Implants: Saline or Silicone (Please Circle)
___	___	Hormone Usage: ___Estrogen ___Progesterone
		___Tamoxifen ___Birth Control
___	___	Currently using: Stopped 1-4 yrs ago _____ Stopped 5-14 yrs ago _____

The above information is correct.

Patient's Signature _____ Today's date _____



FOR TECHNOLOGIST USE:	Tech Initials _____
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