Ft. Jesse Imaging Center | GALE KEERAN Center for Women

Breast MRI Questionnaire

Name: _____ Primary Physician: _____

Reason for Exam:

___ Screening, no problems or symptoms R L
___ Known recent / current breast cancer R L
___ Breast lump or thickening R L
___ Nipple discharge / abnormality R L
___ Enlarged lymph glands under arms R L
___ Breast pain R L
___ Follow-up previous MRI R L
___ Implant problem R L
___ Neoadjuvant therapy follow up
___ Other _____

Areyou currently pregnant or breast feeding? Yes No

Are you still menstruating? Yes No
If yes, first day of last menstrual period ____/____/____
Normal cycle length (days from one period to the next) _____

Have you taken horomones: (birth control / horomone replac Yes No
Type: _____ When did you stop? ____/____/____

Do you have a family history of breast cancer? Yes No
If yes, check all that apply: Mother ____ Aunt ____ Sister ____ Grandmother ____Daughter ____

Are you a breast cancer gene carrier?	Yes	No	Unknown/Never Tested	
Have you had a mammogram?	Yes	No	Date ___/___/___	Where _____
Breast Ultrasound?	Yes	No	Date ___/___/___	Where _____
Previous breast MRI?	Yes	No	Date ___/___/___	Where _____

Have you had any of the following?

			DATE and RESULTS
Cyst Aspiration	R	L	_____
Needle Biopsy	R	L	_____
Surgical Biopsy	R	L	_____
Lumpectomy for Cancer	R	L	_____
Radiation Therapy	R	L	_____
Implants	R	L	_____
Breast Reduction Surgery	R	L	_____
Mastectomy	R	L	_____
Chemotherapy	R	L	_____

If there is any lump or palpable abnormality, please indicate the location on this diagram