

breast mri screening form

breast mri history

Patients previous Mammogram, Breast Ultrasound and Breast MRI images must be here in order to do study.

Mammogram Date _____ Location _____
Breast Ultrasound Date _____ Location _____
Breast MRI Date _____ Location _____

medical history

Any family history of Breast Cancer? No Yes

Mother/Age _____ Sister/Age _____ Daughter/Age _____ Grandmother/Age _____

Last menstrual period date _____ Start of menstruation (Age/Year) _____

Are you post-menopausal? No Yes (Age/Year) _____

Are you pregnant? No Yes (Number of pregnancies) _____

Are you taking hormone replacement? No Yes (Name) _____

How many years have you been taking hormones? _____

Any allergies? No Yes (Name) _____

Diagnosed with cancer other than breast? No Yes (Name) _____

breast surgical history

Do you have breast implants? No Yes (Age/Year) _____

Have you had a breast reduction? No Yes (Age/Year) _____

Have you had a breast biopsy? No Yes

Which breast? Right Left Both

Was it: Surgical Fine Needle Core Findings of biopsy _____

Have you had breast cancer? No Yes Right (Year) _____ Left (Year) _____

Lumpectomy? Right Left Both

Mastectomy? Right Left Both

What treatments have you had? Chemotherapy Radiation Therapy Tamoxifen

Start of treatment _____ End of treatment _____

breast complaints

Right Left Lump, mass, thickening _____

Right Left Nipple discharge _____

Right Left Focal pain _____

Right Left Skin or nipple changes _____

Right Left Other _____

Notes/Comments

I affirm that the above information is correct. I understand it may take a few days for the radiologist to review and interpret the thousands of images generated and processed for this study, and to review your history and prior studies.

Patient signature _____ Date _____

Technologist reviewing history _____ Date _____