MUNSON HEALTHCARE

BREAST MAGNETIC RESONANCE IMAGING INFORMATION FORM

Appointment Information: Date ________________ Arrive ________________

If you cannot make this appointment date and/or time, please call us at least 24 hours in advance.
Phone: 800-968-9292 *option 2* or Fax: 231-935-3473 Monday - Friday 8:00AM to 5:00PM.
PLEASE PRINT

Name _____________________________ MR # _______________ Wt. ________ DOB ________ Age ________

Do you have any discharge from your breasts? ☐ Yes ☐ No
If yes, which one? ☐ Right ☐ Left Color _______________

Do you have a breast lump? ☐ Yes ☐ No
If yes, which one? ☐ Right ☐ Left

Do you have a personal history of breast cancer? ☐ Yes ☐ No
Any relatives with a history of breast cancer? ☐ Yes ☐ No
If yes, who and at what age?
☐ Mother Age _________
☐ Sister Age _________
☐ Grandmother Age _________
☐ Other __________________ Age _________

Are you still menstruating? ☐ Yes ☐ No
If **yes**, date of last menstrual period _____________
If **no**, year of last menstrual period ______________

Do you have any breast pain? ☐ Yes ☐ No
If yes, which breast? ☐ Right ☐ Left

Type of pain _________________________

Date of diagnosis ______________________
Have you been evaluated at a high risk or genetic clinic? ☐ Yes ☐ No
Where? ____________________________
What is your risk? ______________ %
Please include a copy of your high risk report

Do you take birth control pills? ☐Yes ☐ No
If yes, for how long? __________________

Are you currently taking estrogen replacement therapy? ☐ Yes ☐ No
If yes, for how long? ____________________________

Could you be pregnant? ☐ Yes ☐ No

Have you had prior breast surgery? ☐ Yes ☐ No

Have you had breast cancer? ☐ Yes ☐ No

If yes, what type?	**Date**	**Which Side?**
☐ Benign Biopsy	_________________	☐ Right ☐ Left
☐ Lumpectomy	_________________	☐ Right ☐ Left
☐ Mastectomy	_________________	☐ Right ☐ Left
☐ Other ____________________	_________________	☐ Right ☐ Left

PATIENT ID LABEL

Have you had radiation therapy to the breast? ☐ Yes ☐ No
If yes, which side? ☐ Right ☐ Left
What year? _______________

Have you had chemotherapy? ☐ Yes ☐ No
If yes, what year? ____________________

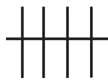
When was your last mammogram? ____________________

When was your last breast MRI? _________

Any mammograms done outside of Munson? ☐ Yes ☐ No
If yes, where and when? ________________________________

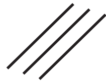
Any MRIs done outside of Munson? ☐ Yes ☐ No

Diagram any scars and findings

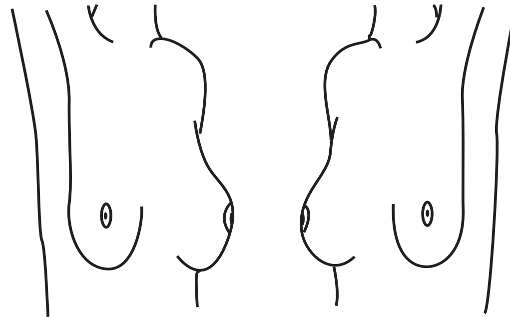

Scar

Palpable Lump

Skin Lesion/Mole


Thickening

Pain



Comments:

REGARDING BREAST IMPLANTS

What type of implants do you currently have?

☐ Silicone
☐ Saline
☐ Dual Lumen
☐ Other (type) ___________________________________
☐ I don't know

When were your current implants placed (year)? ____________________________

Have you had previous implants? ☐ Yes ☐ No

What type of implants have you had in the past?

☐ Silicone
☐ Saline
☐ Dual Lumen
☐ Other (type) ___________________________________
☐ I don't know

Have you had a prior ruptured implant? ☐ Yes ☐ No
When? ________________ Was it replaced? ☐ Yes ☐ No If yes, when (year)? ________________

Why are we doing the breast MRI at this time (what symptoms do you have)?

PATIENT ID LABEL