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 any breast pain? □ Yes □ No
If yes, which breast? □ Right □ Left Type of pain ______________

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 ________

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

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

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

Could you be pregnant? □ Yes □ No

Do you take birth control pills? □ Yes □ No
If yes, for how long? ______________

Have you had prior breast surgery? □ Yes □ No
If yes, what type? □ Benign Biopsy □ Lumpectomy □ Mastectomy □ Other ________________
Date ________________ Date ________________ Date ________________ Date ________________
Which Side? □ Right □ Left □ Right □ Left □ Right □ Left □ Right □ Left

Have you had breast cancer? □ Yes □ No
If yes, what type? □ Benign Biopsy □ Lumpectomy □ Mastectomy □ Other ________________
Date ________________ Date ________________ Date ________________ Date ________________
Which Side? □ Right □ Left □ Right □ Left □ Right □ Left □ Right □ Left
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