



BREAST MRI PATIENT QUESTIONNAIRE

Indication for Breast MRI: _____

Previous Breast Procedures:

<u>Procedure</u>	<u>When?</u>	<u>Where?</u>
Biopsy (FNA) R L	_____	_____
Biopsy (Core) R L	_____	_____
Surgical Biopsy R L	_____	_____
Breast Reduction Surgery	_____	_____
Implants	_____	_____
Other	_____	_____

Personal History of Breast Cancer?

	Y	N	
If yes, Lumpectomy?	Y	N	Date Completed: _____
Mastectomy?	Y	N	Date Completed: _____
Radiation Tx?	Y	N	Date Completed: _____
Chemotherapy?	Y	N	Date Completed: _____
Reconstruction?	Y	N	Date Completed: _____

Do you have a Surgeon, Oncologist or Radiation Therapist? Y N

If yes, please list names: _____

Family History of Breast Cancer? Mother Sister Daughter Other _____

If family history positive, was relative pre-menopausal at time of dx? Y N

Most recent Mammogram: Approx. Date: _____ Facility: _____

Previous Breast Ultrasound: Approx. Date: _____ Facility: _____

Pre-Menopausal? Y N **Post-Menopausal?** Y N

If pre-menopausal, 1st day of last menstrual cycle: _____

Currently on Hormone Replacement Therapy? Y N

If recently discontinued, date: _____

On Thyroid Replacement Hormones? Y N Currently taking Birth Control Pills? Y N

Please list other medications you are currently taking _____

Pregnant? Y N Breast Feeding? Y N Recent Trauma to Breast? Y N

Signature

Date