Valley Radiology CONSULTANTS

MRI BREAST IMAGING EXAMINATION

Name:	Age:
MRN:	Date:
Referring Physician:	Other MD(s):

PATIENT QUESTIONNAIRE

Why are you having this exam?

1. Any breast symptoms? Discharge, lump pain? ☐ Yes ☐ No

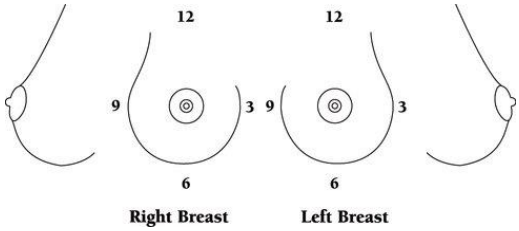
2. Does any relative have a history of breast cancer? ☐ Yes ☐ No Age at diagnosis: _____
   ☐ Mother ☐ Sister ☐ Maternal Grandmother

3. Could you be pregnant? ☐ Yes ☐ No

4. When was the first day of your last menstrual period? (we try to schedule MRI during day 5-10 of your menstrual cycle) _____

5. Do you use estrogen replacement hormones? ☐ Yes ☐ No For how long? _____

6. Any previous breast surgery? ☐ Yes ☐ No Date: _____
   ☐ Breast Implants ☐ SALINE ☐ SILICONE ☐ UNKNOWN
   ☐ Radiation ☐ Chemotherapy Pathology Results: _____
   If yes, mark site on diagram.
   Please indicate location on diagram.
   ☐ Redness ☐ Thickening ☐ Ulceration ☐ Mole
   ☐ Scar ☐ Nipple Retraction ☐ Skin Discoloration
   ☐ Lump ☐ Previous Biopsy



Mammogram(s):
Location: _____

Ultrasound(s) Location: _____

Received: ☐ Yes ☐ No

Received: ☐ Yes ☐ No

Post Surgical Breast:
☐ Biopsy ☐ Lumpectomy ☐ Mastectomy ☐ Axillary Node Biopsy: ☐ Yes ☐ No

Reconstruction: ☐ No ☐ TRAM Flap ☐ Implant ☐ Other

When was last surgery: _____

PET SCAN: ☐ Yes ☐ No If yes, report required.

Post Menopausal: ☐ Yes ☐ No

Pre Menopausal: ☐ Yes ☐ No LMP:_____

If yes, taking HRT: ☐ Yes ☐ No

Pre Scan Reviewed by:_____

To schedule: ☐ Yes ☐ No