Lerman Diagnostic Imaging
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BREAST MRI QUESTIONNAIRE

NAME: _____ AGE: _____ SEX: o M o F

DIAGNOSIS (Why are you having this study?):

_____

_____

PLEASE CHECK EACH BOX THAT APPLIES TO YOU (AND ANSWER QUESTIONS):

When was the first day of your last menstrual period? _____
Do you have or have you had breast cancer? o Yes o No If yes, when? _____
Which breast? o Right o Left
Did the tumor spread elsewhere in your body? o Yes o No
If yes, where? _____
What type of therapy did you receive?_____
Surgery o Yes o No
Lumpectomy o Yes o No
Mastectomy o Yes o No
Chemotherapy o Yes o No
Radiation therapy o Yes o No
Hormonal therapy o Yes o No
Have you had breast surgery? o Yes o No
If so, what type?_____
o Biopsy o Right o Left
o Lumpectomy for benign breast mass o Right o Left
o Breast implants o Right o Left
If so, what type? (ie. saline or silicone) _____
When were they placed? _____
o Breast reduction o Right o Left
Have you had a breast MRI before? o Yes o No
If yes, where? _____ Results?_____
When was your last mammogram? _____
Results?_____
_____
Have you had a breast ultrasound examination? o Yes o No
If yes, where? _____ Results? _____
Do you feel a breast lump or mass? o Yes o No
If yes, for how long? _____
Is there any family history of breast cancer o Yes o No
Relationship to patient _____
Age at time of diagnosis _____