MRI Breast Questionnaire

Name: ______________________________________ Age ________ Sex_______ Weight___________

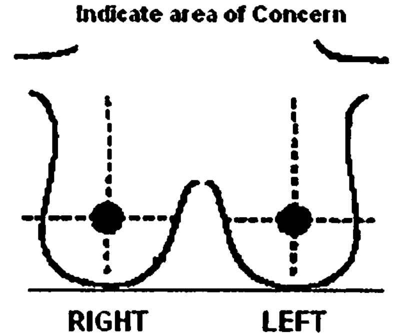
PATIENTS WITH CEREBRAL ANEURYSM CLIPS OR PACEMAKERS CANNOT UNDERGO AN MRI

Instructions: Mark the drawing according to the location of any breast lumps or surgery sites.

Describe your symptoms:

____

Have you ever had an injury to this site? Yes No
If so, when? ____________________
Have you had a previous mammogram? Yes No
When? __________________ Where? ______________________
Previous breast surgery? Yes No Date: _______________
Right _____ Left _____ Benign _____ Malignant _____
Other Surgeries: ____



DO YOU HAVE A PACEMAKER? Yes No
IF YES, PLEASE NOTIFY THE TECHNOLOGIST IMMEDIATELY

Are you currently on dialysis or have chronic renal failure?	Yes	No
Do you have a history of hypertension?	Yes	No
Do you have a history of diabetes?	Yes	No
Have you ever had a Liver Transplant?	Yes	No
Have you ever been diagnosed with severe Hepatic Disease?	Yes	No
Have you ever worked as a metal worker?	Yes	No
If yes, could you have metal in your head, eyes or skin?	Yes	No
Do you have metal plates, pins, screws, nails or clips in your body?	Yes	No
Do you wear a hearing aid?	Yes	No
Do you have implanted devices?	Yes	No
Have you ever had surgery on your head (ex: brain, ears or eyes)?	Yes	No
Could you be pregnant? Date of last menstrual period: _____________	Yes	No
Are you breast feeding?	Yes	No
Have you been diagnosed with cancer?	Yes	No
What type? ______________________________		
Have you had radiation or chemotherapy treatments?	Yes	No
Date of your last treatment: ____________________		
Is this procedure being done due to an automobile accident?	Yes	No
Is this procedure being done due to a work related injury?	Yes	No
Have you taken hormones? (Birth control or hormone replacement)	Yes	No
Type ______________________ When did you stop? ______________		
Family history of breast cancer?	Yes	No
Mother _____ Aunt _____ Sister _____ Grandmother ______		

Reason for exam:

____ Implants
____ Breast Lumps (R___ L___)
______ Enlarged Lymph Nodes Under Arm
______ Known Breast Cancer (R___ L___)
_____ Nipple Discharge(R___ L___)
_____ Other: ____________________

I attest that the above information is correct to the best of my knowledge.

Signature: ____ Date: ______________________________

TO BE COMPLETED BY DEPARTMENTAL STAFF

Exam: ________________________ Reason for Exam: ____
Contrast type: ___________________ Amount/Rate: ___ _______________ Site: _____________________________
Technologist: ___________________ Date: __________ # of Images: _________ GFR: __________ mL/min/1.73m2
Creatinine: ____________________ Reference Range: .6-1.5 mg/dl