BREAST MRI QUESTIONNAIRE

Instruction:
To be completed by patient prior to imaging.

Name:

Date of birth:

Weight:________lbs.

Height:_________inches

ATTENTION: Patient safety is our primary concern. MRI contains a very strong magnet and is ALWAYS ON. Before you are allowed into the MRI environment, you must remove ALL metallic objects including hearing aids, dentures, partial plates, keys, beepers, cell phones, eyeglasses, hair pins, barrettes, jewelry, body piercing jewelry, watch, safety pins, paper clips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knives, nail clippers, tools, clothing with metal fasteners and clothing with metallic threads. Some metal objects can interfere with your scan or even be of danger to you. Please answer the following questions CAREFULLY. Please consult with the MRI Technologist or Radiologist if you have ANY questions BEFORE you enter the MRI system.

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING (mark all that apply)

☐ Electrodes  ☐ Bladder ring
☐ Brain surgery clips  ☐ Intrauterine device (IUD)
☐ Brain aneurysm clips  ☐ Harrington rods
☐ Aortic clips  ☐ Any injury involving metal
☐ Carotid clips  ☐ Shrapnel/gunshot wounds
☐ Defibrillator  ☐ Pain patch
☐ Middle/Inner ear prosthesis  ☐ Medicine patch
☐ Hearing aids  ☐ Tissue expander
☐ Heart valve  ☐ Body piercing jewelry
☐ Medication pump  ☐ Tattoos or permanent makeup
☐ Neuro/bone stimulator(i.e., TENS unit)  ☐ Metal fragments in the head, eye or skin
☐ Joint replacement  ☐ Fractured bones (treated with metal rods, plates, screws, nails or clips)

MEDICAL HISTORY

Have you ever had any problem related to a previous MRI examination, including a reaction to contrast or claustrophobia?  ☐ No  ☐ Yes, describe:___________________________________________________________

Do you have a history or kidney disease or dialysis?  ☐ No  ☐ Yes: ☐ Unknown  ☐ Stage 1  ☐ Stage 2
☐ Stage 3  ☐ Stage 4  ☐ Stage 5

Do you have a history of diabetes?  ☐ No  ☐ Yes

Do you have high blood pressure?  ☐ No  ☐ Yes

Do you have any allergies (medications, latex, shell fish, intravenous dye)?  ☐ No  ☐ Yes, list allergy and reaction:

________________________________________________________________________________________

________________________________________________________________________________________

Do you CURRENTLY take any medication including birth control pills, patch or injections?  ☐ No  ☐ Yes, (list medication):

________________________________________________________________________________________

________________________________________________________________________________________

Have you ever taken hormone replacement therapy?  ☐ No  ☐ Yes

HAVE YOU EVER HAD ANY OF THE FOLLOWING BREAST IMAGING STUDIES

Mammogram:  ☐ No  ☐ Yes, date:__________________ where:

Breast ultrasound:  ☐ No  ☐ Yes, date:______________ where:

Breast MRI:  ☐ No  ☐ Yes, date:__________________ where:
When was the first day of your last menstrual period? _______________

Have your menstrual periods stopped permanently? ☐ No ☐ Yes: ☐ stopped naturally ☐ stopped due to surgery

Are you currently pregnant? ☐ No ☐ Yes

Are you currently Breast feeding? ☐ No ☐ Yes

Why are you having this Breast MRI today? ________________________________________________________
_____________________________________________________________________________________

HAVE YOU HAD ANY OF THE FOLLOWING (list results, if known)?

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Left</th>
<th>Right</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fine needle aspiration or Cyst Aspiration:</td>
<td></td>
<td>☐</td>
</tr>
<tr>
<td>Date:_____ Result:_______</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Needle or core biopsy (stereotactic or ultrasound guidance):</td>
<td></td>
<td>☐</td>
</tr>
<tr>
<td>Date:_____ Result:_______</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgical excisional biopsy:</td>
<td></td>
<td>☐</td>
</tr>
<tr>
<td>Date:_____ Result:_______</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lumpectomy for breast cancer:</td>
<td></td>
<td>☐</td>
</tr>
<tr>
<td>Date:_____ Result:_______</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Mastectomy reconstruction? ☐ No ☐ Yes

Breast plastic surgery: ☐ No ☐ Yes, type: ☐ Lift ☐ Reduction ☐ Saline implants ☐ Silicone Implants

IF YOU HAVE BEEN TOLD YOU HAVE BREAST CANCER, PLEASE INDICATE TREATMENT

☐ Radiation to breast or chest Date:______________________
☐ Chemotherapy Date:______________________
☐ Lymph node sampling Date:______________________

HAVE YOU EVER BEEN DIAGNOSED WITH ANY OTHER TYPE OF CANCER (other than breast cancer)?

☐ No ☐ Yes, indicate type(s) and age at diagnosis:

Type:________________________________________ Age:_____ Type:________________________________________ Age:_____

FAMILY HISTORY

Have any of your BLOOD relatives (Mother, Sister, Daughter) been diagnosed with Breast Cancer?

☐ No ☐ Yes, list who and age of diagnosis:

Relationship:________________________ Age:_____ Relationship:________________________ Age:_____

_______________________________  ________________  _________________
Signature of Patient or Decision Maker Relationship to Patient if Decision Maker

_______________________________  ________________  _________________
Print Name Date Time