# MRI Breast Patient Questionnaire

**Your name:** _____ **Birthdate:** _____/_____/_____

**Your primary physician:**_____ **Surgeon:**_____

**Reason for exam:** (Check all that apply & circle appropriate side)

Implants Evaluation _____ Enlarged Lymph Glands (under arm) _____ Breast lump (Right/Left) _____

Known breast cancer _____(Right/Left) Nipple discharge _____ (Right/Left) _____ Other: _____

**Previous studies:**

Mammogram Yes____ No____ Date_____/_____/_____ Where?_____

Ultrasound Yes____ No____ Date_____/_____/_____ Where?_____

MRI Yes____ No____ Date_____/_____/_____ Where?_____

**Have you ever been diagnosed with Breast Cancer:**

Yes____ No____ Date_____/_____/_____ Treatment: _____

**Have you ever had Radiation Therapy for Breast Cancer:** Yes____ No____ Date_____/_____/_____

**Previous breast surgery?** Yes _____ No _____

Right _____ Left _____ Benign _____ Malignant _____

**Are you still menstruating?** Yes _____ No _____ **If yes, first day of last menstrual period** _____/_____/_____

Normal cycle length _____ (days from one period to next)

**Have you taken birth control pills or hormone replacement therapy in the last six months?** Yes _____ No _____

If yes, are you presently taking them? Yes _____ No _____ If no, when did you discontinue use? _____/_____/_____

**Family history of breast cancer?**

Mother _____ Aunt _____ Sister _____ Grandmother _____

**PLEASE SHOW LOCATION OF ANY BREAST LUMPS OR SURGERY SITES**