Breast MRI Screening Form

Name_____ DOB_____

Today's Date_____ Referring Doctor_____

Your Symptoms/Reason for this Exam

___ Known Breast Cancer (__R __L) ___ Nipple Discharge (__R __L) ___ Breast Lump (__R __L)

___ High Risk Screening ___ Enlarged Lymph Nodes (_R _L) ___ Breast Implants

___ Dense Breasts ___ Abnormal mammogram ___ Other _____

Where were your most recent mammograms done?

Date_____ Location_____

Menstrual History

If you are still menstruating (pre-menopausal), please fill out this section:

First day of last period_____ Normal cycle length_____ Are your cycles regular? YES NO

**** note: patients must be 7-12 days from start of last cycle*

Do you take hormones (birth control)? YES NO

Are you lactating (breast-feeding)? YES NO

If you are post-menopausal, please fill out this section:

Year of last menstrual period_____

Do you take hormones (hormone replacement)? YES NO

If yes, when did you stop taking them? _____

****note: must be stopped 1 month prior to MRI*

Breast History

Have you had breast surgery? Right Left NONE

Reason/outcome_____

Family history of breast cancer? YES NO

If yes, who?_____

Known BRCA gene mutation? YES NO

History of Lymphoma or other cancer with radiation to the chest? YES NO

Patient Signature_____ Date_____

Tech Comments_____

_____

Reviewed by Tech (Signature)_____ Date _____

**** Patient should ALSO fill out MRI screening and MRI contrast screening forms**