Regional Medical Imaging
Breast MRI Patient History Form

Clinical Details: Staff use only	
Gail Score:	Tech:
Contrast Dose:	History:

Patient History

Today's Date: **Primary Physician:** **Surgeon:**

Patient Name: **DOB:** **Weight:** **Height:**

If Patient is a minor or nursing home patient-Name of accompanying adult and relationship to patient:

Next appointment with physician/surgeon

Your age at first live birth | Age at first menstrual cycle | Date of last menstrual cycle

Family History of Breast Cancer & Age at Diagnosis:

Grandmother | Mother | Sister | Aunt | Daughter | Other

Reason for Today's Exam: (please check areas that apply)

Enlarged lymph glands under arm (R ☐ L ☐) | Breast lump (R ☐ L ☐) | Nipple discharge (R ☐ L ☐)

Abnormal Mammogram (R ☐ L ☐) | Abnormal Ultrasound (R ☐ L ☐) | Dense Breasts (R ☐ L ☐)

Breast Cancer: Personal History of Breast Cancer (R ☐ L ☐) | New Diagnosis of Breast Cancer (R ☐ L ☐)

Stage or Size of Cancer | Breast Implants (R ☐ L ☐)

Undergoing treatment (R ☐ L ☐) | Chemotherapy Dates: Start Finish

Radiation Therapy Dates: Start Finish

Surgical History of the Breast(s) Date(s) & Results

Right Breast (please check one & list the date)	**Left Breast** (please check one & list the date)
☐ Mastectomy ☐ Lumpectomy	☐ Mastectomy ☐ Lumpectomy
Results:	Results:
☐ Surgical/Needle Biopsy	☐ Surgical/Needle Biopsy
Results:	Results:
☐ Cyst aspiration	☐ Cyst aspiration
Results:	Results:

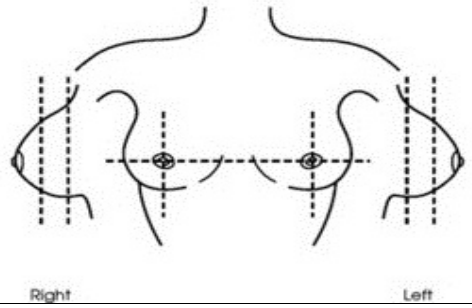
Previous Mammogram, Breast MRI, or US Breast?

Type, Date(s), & Facility?

Use of oral hormones or cream in the last 6 months?

Type?

How long have you been off hormones?



Personal history of Cancer other than Breast? ☐Yes ☐ No

Type(s) & Date(s):

Have you or your doctor felt any lumps?
☐Yes ☐ No
*Please show location of any breast lumps or surgery sites on the above picture: **X = Lumps --- Surgery/Scar**

Smoking History-Lung Screening

☐ **None Provided**	☐ **Current**	**Packs per day:**	**Number of years smoked:**
☐ **Never**	☐ **Past**	**Quit - How long ago?**	**History of Lung cancer?**

PLEASE CONTINUE ON THE NEXT PAGE

WARNING: Certain implants, devices, or objects may be hazardous to you in the MR environment or MR system room. Do not enter the MR environment of MR system room if you have any questions or concerns regarding an implant, device, or object.
Be Advised, the MR system magnet is ALWAYS on!

Please indicate if you have any of the following:					
Yes	No		Yes	No	
☐	☐	**Pacemaker/defibrillator**	☐	☐	**Implanted drug pump**
☐	☐	**Aneurysm clips or coils**	☐	☐	**Insulin Pump**
☐	☐	**Electronic implant or device**	☐	☐	**Loop recorder**
☐	☐	**Brain, eye, ear surgery**	☐	☐	**Open heart surgery**
☐	☐	**Cochlear Implant or middle ear implant**	☐	☐	**Any metallic fragment or foreign body**
☐	☐	**Metal removed from eyes**	**Cleared by:**		
☐	☐	**Internal Stimulator**	**Type:**		
☐	☐	**Artificial or prosthetic limb**	**Type:**		
☐	☐	**Any type or Prosthesis or implant**	**Type:**		
☐	☐	**Other implant**	**Type:**		

Medications: _____

_____

_____

Allergies: _____

Clinical Information:					
Yes	No		Yes	No	
☐	☐	**Chance of Pregnancy** **Last Menstrual Period:**	☐	☐	**Breastfeeding** **If yes: recommend 24 hour discard**
☐	☐	**Renal failure**	☐	☐	**Diabetes**
☐	☐	**Single Kidney/Kidney Transplant**	☐	☐	**Blood Born Contagious Diseases**
☐	☐	**Dialysis**	☐	☐	**Seizure History**
☐	☐	**High Blood Pressure**	☐	☐	**Anemia/Sickle Cell Anemia**
☐	☐	**Stroke/TIA**	☐	☐	**Latex Allergy**
☐	☐	**Asthma/Breathing Disorders**			
☐	☐	**Previous Contrast Reaction**	**Name of Dye**		**Type of Reaction**

Contrast Consent:

I attest that the above information is correct to the best of my knowledge. I have read and understand the entire contents of this form and have had the opportunity to ask questions regarding the information on this form.
I GIVE CONSENT TO HAVE CONTRAST INJECTED IF REQUIRED, FOR MY EXAM.

Signature of Person Completing Form: _____