



Breast MRI Questionnaire

Name _____ Age _____ Referring Doctor _____

Patient Phone Number: _____ Referring Physician Phone Number: _____

Date of last menstrual cycle: _____

PRIOR EXAMS

Have you had a recent:

Mammogram? Yes No Breast ultrasound? Yes No

If so, where and when? _____

Have you ever had a breast MRI before? Yes No

If so, where and when? _____

If these exams were not performed in our office we will need you to bring the original exams and copies of your reports to our office on the day of your exam.

Have you ever had breast cancer? Yes No If no, skip the next section, and go to family history of breast cancer. If yes, when were you diagnosed? _____

What type of therapy did you receive? _____

Did you have breast surgery for cancer? (Lumpectomy or mastectomy) _____

Did you have radiation therapy? Yes No Did you have chemotherapy? Yes No

Did you have hormonal therapy? Yes No

FAMILY HISTORY OF BREAST CANCER

Have any of your blood relatives ever had breast cancer? Yes No

If yes, what relationship? _____ What age? _____

Are you a breast cancer gene carrier? Yes No Unknown/never tested

What is the reason that your doctor has requested this exam? _____

SURGICAL HISTORY

Have you ever had a needle biopsy? Yes No

Have you ever had a surgical biopsy? Yes No

If yes, what were the results? _____

Did you ever have breast implants? If so what type (silicone or saline) and when were they placed?

Do you have a breast lump? Yes No

Please indicate the location on this diagram.

