MD Imaging

a Rezolut partner

MRI BREAST PATIENT QUESTIONNAIRE

NAME____

DATE_____________________________DATE OF BIRTH__________________________

PLEASE ANSWER EACH QUESTION AS ACCURATELY AS POSSIBLE

Reason for today's exam: (check all that apply & circle appropriate side)
Dense Breasts on Mammo______ Enlarged Lymph Glands under arm______(Right/Left) Breast Lump______(Right/Left)
Known Breast Cancer______(Right/Left) Nipple Discharge______(Right/Left) High Lifetime Risk Assessment_____If yes, what %_______
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____ If yes, right or left (circle one)? Date____/____/____

Previous breast surgeries or biopsies? Yes____ No____ Dates_____________________________________

Right____Left____Benign____Malignant____

Have you ever had Chemotherapy for breast cancer? Yes____ No____Dates______________________________

Have you ever taken Tamoxifen for breast cancer? Yes____ No____Dates______________________________

Have you ever had Radiation Therapy for breast cancer? Yes____ No____ Dates__________________________

Have you had genetic testing for the BRCA gene? Yes____ No____Result______________________________

Breast Implants? Yes____ No____ If yes, what type of implants:____

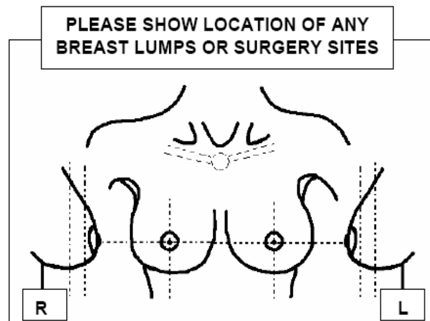
Do you have a tissue expander present at this time? Yes____ No____

Are you having monthly menstrual cycles? Yes____ No____ If yes, first day of last menstrual period____/____/____

Normal cycle length (Days from one period to the next)______________

Are you currently taking hormone therapy or oral contraceptives? Yes____ No____Medication and dosage________________________

Family history of breast cancer? Yes____ No____ If yes: Mother____ Sister____ Grandmother____(paternal or maternal?)
Aunt____(paternal or maternal?)



MAGNETIC RESONANCE (MR) PROCEDURE SCREENING FORM FOR PATIENTS

Date _____/_____/_____ Referring Physician ____

Name ____ Age ________ Height ________ Weight ________
Last name First name Middle Initial

Date of Birth _____/_____/_____ Male ❐ Female ❐ Body Part to be Examined ____________________
month day year

Reason for MRI and/or Symptoms ____

1. Have you had prior surgery or an operation (e.g., arthroscopy, endoscopy, etc.) of any kind? ❐ No ❐ Yes
   If yes, please indicate the date and type of surgery:
   Date _____/_____/_____ Type of surgery ____
   Date _____/_____/_____ Type of surgery ____
2. Have you had a prior diagnostic imaging study or examination (MRI, CT, Ultrasound, X-ray, etc.)? ❐ No ❐ Yes
   If yes, please list:

	Body part	Date	Facility
MRI	________________________	_____/_____/_____	__________________________________
CT/CAT Scan	________________________	_____/_____/_____	__________________________________
X-Ray	________________________	_____/_____/_____	__________________________________
Ultrasound	________________________	_____/_____/_____	__________________________________
Nuclear Medicine	________________________	_____/_____/_____	__________________________________
Other__________	________________________	_____/_____/_____	__________________________________

3. Have you experienced any problem related to a previous MRI examination or MR procedure? ❐ No ❐ Yes
   If yes, please describe: ____
4. Have you had an injury to the eye involving a metallic object or fragment (e.g., metallic slivers, shavings, foreign body, etc.)? ❐ No ❐ Yes
   If yes, please describe: ____
5. Have you ever been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel, etc.)? ❐ No ❐ Yes
   If yes, please describe: ____
6. Are you currently taking or have you recently taken any medication or drug? ❐ No ❐ Yes
   If yes, please list:____
7. Are you allergic to any medication? ❐ No ❐ Yes
   If yes, please list:____
8. Do you have a history of asthma, allergic reaction, respiratory disease, or reaction to a contrast medium or dye used for an MRI, CT, or X-ray examination? ❐ No ❐ Yes
9. Do you have anemia or any disease(s) that affects your blood, a history of renal (kidney) disease, or seizures? ❐ No ❐ Yes
   If yes, please describe: ____

For female patients:

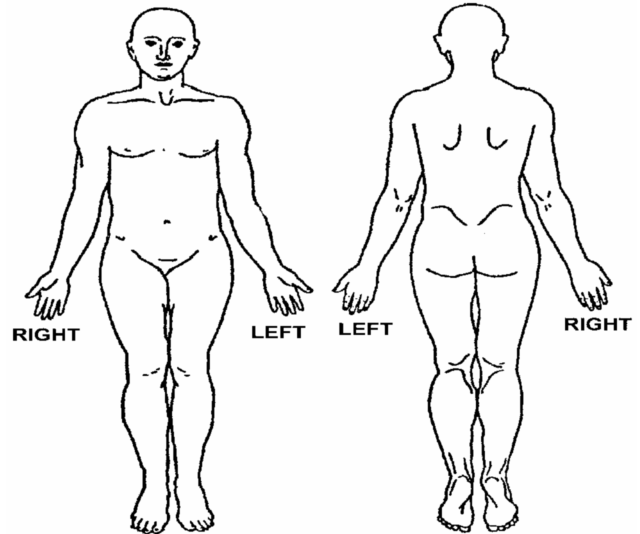
10. Date of last menstrual period:_____/_____/_____ Post menopausal? ❐ No ❐ Yes
11. Are you pregnant or experiencing a late menstrual period? ❐ No ❐ Yes
12. Are you taking oral contraceptives or receiving hormonal treatment? ❐ No ❐ Yes
13. Are you taking any type of fertility medication or having fertility treatments? ❐ No ❐ Yes
    If yes, please describe: ____
14. Are you currently breastfeeding? ❐ No ❐ Yes

WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure (i.e., MRI, MR angiography, functional MRI, MR spectroscopy). Do not enter the MR system room or MR environment if you have any question or concern regarding an implant, device, or object. Consult the MRI Technologist or Radiologist BEFORE entering the MR system room. The MR system magnet is ALWAYS on.

Please indicate if you have any of the following:

❒ Yes ❒ No Aneurysm clip(s)
❒ Yes ❒ No Cardiac pacemaker
❒ Yes ❒ No Implanted cardioverter defibrillator (ICD)
❒ Yes ❒ No Electronic implant or device
❒ Yes ❒ No Magnetically-activated implant or device
❒ Yes ❒ No Neurostimulation system
❒ Yes ❒ No Spinal cord stimulator
❒ Yes ❒ No Internal electrodes or wires
❒ Yes ❒ No Bone growth/bone fusion stimulator
❒ Yes ❒ No Cochlear, otologic, or other ear implant
❒ Yes ❒ No Insulin or other infusion pump
❒ Yes ❒ No Implanted drug infusion device
❒ Yes ❒ No Any type of prosthesis (eye, penile, etc.)
❒ Yes ❒ No Heart valve prosthesis
❒ Yes ❒ No Eyelid spring or wire
❒ Yes ❒ No Artificial or prosthetic limb
❒ Yes ❒ No Metallic stent, filter, or coil
❒ Yes ❒ No Shunt (spinal or intraventricular)
❒ Yes ❒ No Vascular access port and/or catheter
❒ Yes ❒ No Radiation seeds or implants
❒ Yes ❒ No Swan-Ganz or thermodilution catheter
❒ Yes ❒ No Medication patch (Nicotine, Nitroglycerine)
❒ Yes ❒ No Any metallic fragment or foreign body
❒ Yes ❒ No Wire mesh implant
❒ Yes ❒ No Tissue expander (e.g., breast)
❒ Yes ❒ No Surgical staples, clips, or metallic sutures
❒ Yes ❒ No Joint replacement (hip, knee, etc.)
❒ Yes ❒ No Bone/joint pin, screw, nail, wire, plate, etc.
❒ Yes ❒ No IUD, diaphragm, or pessary
❒ Yes ❒ No Dentures or partial plates
❒ Yes ❒ No Tattoo or permanent makeup
❒ Yes ❒ No Body piercing jewelry
❒ Yes ❒ No Hearing aid
(Remove before entering MR system room)
❒ Yes ❒ No Other implant ________________________
❒ Yes ❒ No Breathing problem or motion disorder
❒ Yes ❒ No Claustrophobia

Please mark on the figure(s) below the location of any implant or metal inside of or on your body.



IMPORTANT INSTRUCTIONS

Before entering the MR environment or MR system room, you must remove all metallic objects including hearing aids, dentures, partial plates, keys, beeper, cell phone, eyeglasses, hair pins, barrettes, jewelry, body piercing jewelry, watch, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools, clothing with metal fasteners, & clothing with metallic threads.

Please consult the MRI Technologist or Radiologist if you have any question or concern BEFORE you enter the MR system room.

NOTE: You may be advised or required to wear earplugs or other hearing protection during the MR procedure to prevent possible problems or hazards related to acoustic noise.

I attest that the above information is correct to the best of my knowledge. I read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and regarding the MR procedure that I am about to undergo.

Signature of Person Completing Form: ______________________________ Date _____/_____/_____
Signature

Form Completed By: ❒ Patient ❒ Relative ❒ Nurse ______________________________
____
Print name Relationship to patient

Form Information Reviewed By: ____
Print name Signature