



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: _____

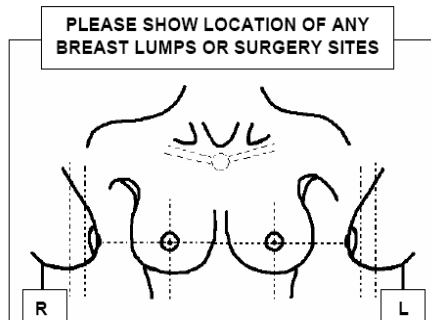
Do you have a tissue expander present at this time? Yes ___ No ___

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?)





Superior Care through Advanced Technology

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 _____

Table with 4 columns: Imaging type (MRI, CT/CAT Scan, X-Ray, Ultrasound, Nuclear Medicine, Other), Body part, Date, Facility. Includes checkboxes for No/Yes.

- 3. Have you experienced any problem related to a previous MRI examination or MR procedure? [] No [] Yes
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
5. Have you ever been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel, etc.)? [] No [] Yes
6. Are you currently taking or have you recently taken any medication or drug? [] No [] Yes
7. Are you allergic to any medication? [] No [] Yes
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

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
14. Are you currently breastfeeding? [] No [] Yes

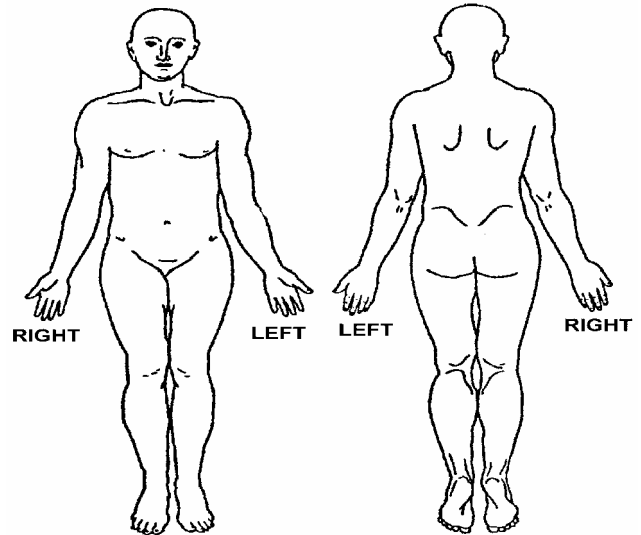


WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure (i.e., MRI, MR angiography, functional MRI, MR spectroscopy). Do not enter the MR system room or MR environment if you have any question or concern regarding an implant, device, or object. 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: _____
Signature

Date ____/____/____

Form Completed By: Patient Relative Nurse _____

Print name

Relationship to patient

Form Information Reviewed By: _____
Print name Signature