



"The Leader in Quality Medical Imaging"

Label

MRI Breast Intake Form

When was your last mammogram?	Where:
When was your last breast US?	Where:

- Have you been diagnosed with breast cancer? YES NO
What year? _____
- Have you had a prior breast MRI? YES NO
When: _____ Where: _____
- Do you have implants? YES NO
If YES, are they:
 Saline Silicone Combination saline & silicone
- Does any relative have a history of breast cancer? YES NO
If YES, who:
 Mother @ age ____ Sister @ age ____
 Grandmother @ age ____ Other: _____
- Are you still menstruating? YES NO
If YES: Date of last menstrual period: _____
If NO: Year of last menstrual period: _____
- Do you use estrogen replacement therapy? YES NO
If YES: For how long? ____ Date of last dose: _____
- Is there any chance that you could be pregnant? YES NO
- Have you had prior breast surgery? YES NO
If YES, what type:
 Benign biopsy _____ Right _____ Left _____ Year
 Lumpectomy _____ Right _____ Left _____ Year
 Mastectomy _____ Right _____ Left _____ Year
- Have you had radiation therapy to the breast? YES NO
If YES: which side: _____ Right _____ Left _____ Year

****If you would like a chaperone for your exam, please inform your technologist****

↓ PLEASE DO NOT WRITE BELOW THIS LINE ↓

CLINICAL HX/TECH NOTES

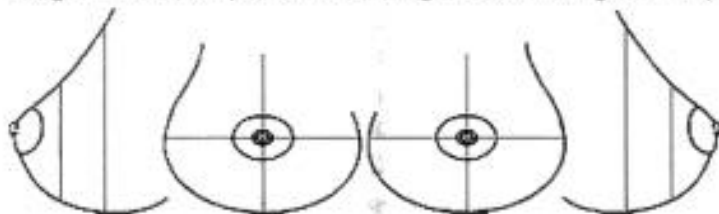
The purpose of MRI is:

- Treatment planning
- Response to chemotherapy
- Other _____

Diagram scars, lumps, skin thickening or other findings

MUST BE AVAILABLE PRIOR TO READING MRI

- Prior mammogram report and film
- Prior ultrasound report, u/s images if possible
- Copy of prior Breast MRI report and original data on disk if prior MRI was done at some facility
- Copy of Physicians order



_____ mL's Magnavist

_____ Secs post contrast to scan

Tech Initials: _____