BREAST MRI QUESTIONNAIRE **Saint Clares Heath System** **Department of Radiology**	**Name:** _____ **Date of Birth:** _____ **MRN:** _____ **Today's Date:** _____

The information below is important to us in interpreting your breast MRI. Please check an answer box for each question and fill in the blanks.

1. Have you had a previous mammogram, breast ultrasound, or breast MRI done elsewhere? Place _____ Address _____	☐ Yes ☐ No
2. Are you having this breast MRI today because you or your doctor were concerned about one of the breast problems listed below? ☐ Yes, I was concerned about the breast problem(s) checked below: ☐ Yes, my doctor was concerned about the breast problem(s) checked below: **(Checked the reason for today's breast MRI and circle R or L to indicate Right breast or Left breast)** **R L** ☐ Previous abnormal mammogram or ultrasound **R L** ☐ Lump **R L** ☐ Infection **R L** ☐ Pain or tenderness **R L** ☐ Nipple discharge **R L** ☐ Breast enlargement **R L** ☐ Other (please specify) **R L** ☐ BRCA+/Strong Family History	
3. Are you pregnant or nursing a baby?	☐ Yes ☐ No
4. Have you menstrual periods stopped permanently? ☐ No ☐ Not sure ☐ Maybe (My periods are less frequent) ☐ Yes, periods stopped naturally ☐ Yes, but I now have periods induced by hormones ☐ Yes, uterus removed by surgery If yes, how old were you when your periods stopped naturally or due to surgery? _____ If you are still having menstrual periods, where are you in your cycle? _____ How old were you when you had your first menstrual period? _____ ☐ Less than 12 ☐ 12-14 ☐ More than 14	

5. Are you currently taking Tamoxifen	☐ Yes ☐ No
6. Have you been diagnosed with Breast Cancer? If yes, when were you diagnosed? _____ Which breast affected? ☐ Right ☐ Left ☐ Both Method & Date of treatment? ☐ Radiation _____ ☐ Chemotherapy _____ ☐ Surgery _____	☐ Yes ☐ No
7. Have you had any type of cancer other than breast cancer? If yes, what type (e.g. Lymphoma, Melanoma, Ovarian, Colon, etc.) _____ If yes, method of treatment (Radiation, chemotherapy, surgery) _____ Date of Diagnosis _____	☐ Yes ☐ No
8. Do you have breast implants? If yes, what type? ☐ Silicone ☐ Saline If yes, date implanted? _____	☐ Yes ☐ No
9. Have you ever had a breast biopsy? If yes, when/where? _____ If yes, what type? (Ultrasound, Stereotactic, MRI, etc.) _____ If yes, what were the results of the biopsy? _____	☐ Yes ☐ No
10. Have you ever had any prior imaging studies (e.g. CT Scan, MRI, Pet, Xray, etc)? If yes, what type? _____ If yes, when? _____ If yes, where? _____	☐ Yes ☐ No

If you have any other medical history that you would like us to know about, or that you think might be related to your problem, please tell the technologist or radiologist.

Please draw any surgical or biopsy scars and locations of palpable lumps on the diagram below: