

Weill Cornell Imaging at NewYork-Presbyterian

PATIENT INFORMATION

Patient Name _____ D.O.B. _____ Date _____

Last menstrual cycle _____ Last clinical breast exam _____

Hormone replacement therapy (Yes) (No)

Reason for today's examination _____

IMAGING STUDIES

Have you had any recent breast imaging studies?

Mammogram (Yes) (No) Date _____ Location _____

Ultrasound (Yes) (No) Date _____ Location _____

M.R.I (Yes) (No) Date _____ Location _____

Do you have the films with you today? (Yes) (No)

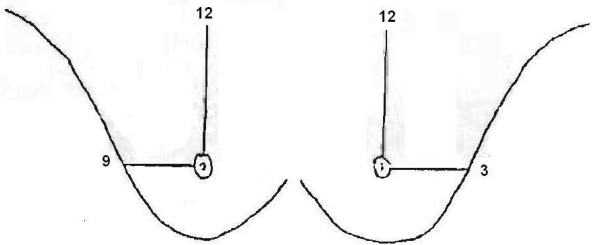
Which Breast? Right Breast Left Breast
Date _____ Place _____

Outcome* _____ *Benign or Malignant

Do you have implants (Yes) (No) If yes, please indicate Silicone Saline

For office use only:

Per _____ Gadolinium Dose _____ ml



Wet Reading
