Weill Cornell Imaging

NewYork-Presbyterian | Weill Cornell Medicine

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*Please complete **MRI General Safety Form** in addition to this form*

(office use)

MRI: BREAST FORM

Patient Name: _____ Date of Birth: _____ 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 _____

MRI ◯ 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 a current diagnosis of breast cancer? ◯ Yes ◯ No If Yes: ☐ Right Breast ☐ Left Breast

Do you have a history of breast cancer? ◯ Yes ◯ No If Yes: ☐ Right Breast ☐ Left Breast

Have you had lymph nodes removed? ◯ Yes ◯ No If Yes: ☐ Right Breast ☐ Left Breast

Do you have implants? ◯ Yes ◯ No If Yes, please indicate: ☐ Silicone ☐ Saline

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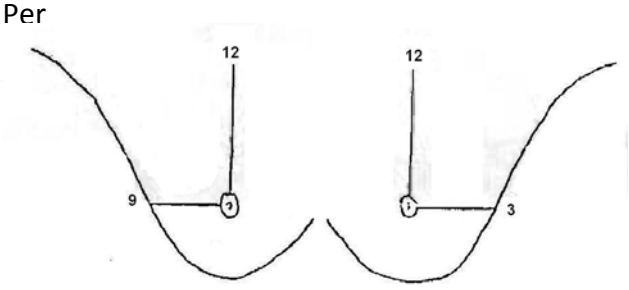
(FOR OFFICE USE ONLY)

Per

Gadolinium Dose _____ ml



Right ☐ Left ☐

Wet Reading

_____

_____