

(Office use)

MRI: BREAST INFORMATION FORM

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 _____

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

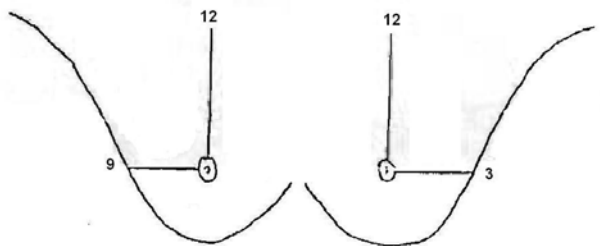
Have you had lymph nodes removed? Yes No **If Yes:** Right Breast Left Breast

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

(FOR OFFICE USE ONLY)

Per _____

Gadolinium Dose _____ ml



Right

Left

Wet Reading