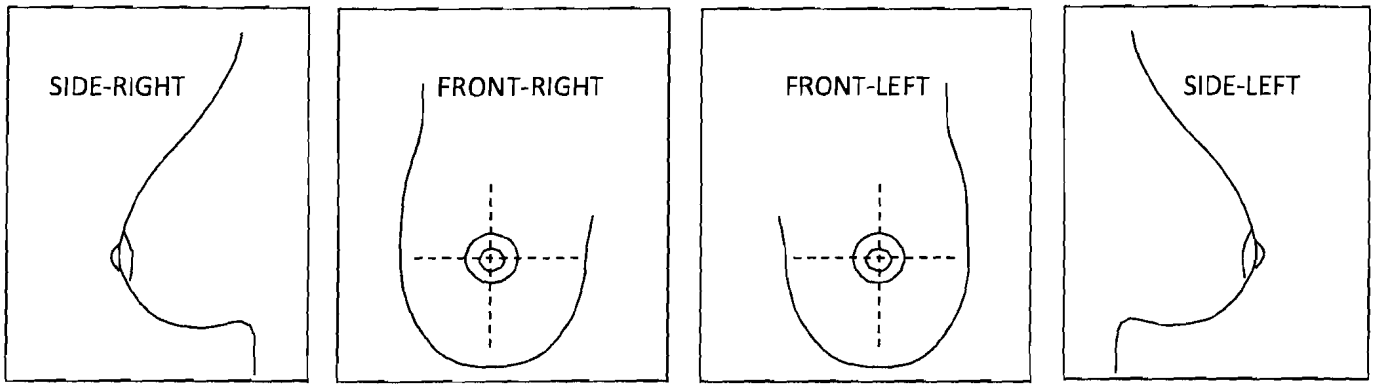
Advanced Imaging Breast MRI History Form

Name _____ **DOB** _____

Reason for exam: (check all that apply and appropriate side)

____Dense breasts on mammogram
____Palpable breast lump (Right /Left)
____Known breast cancer (Right / Left)
____Enlarged lymph nodes under arm (Right / Left)
____Nipple discharge (Right / Left)
____Implant problem (Right / Left)
____Other_____

Please marks any know lumps, pain or physical scars as follows: ‡ scar, • palpable lump, ≈ pain



Have you had any of the following:

	Left	Right	Date and Result
____Cyst aspiration	___	___	_____
____Needle biopsy	___	___	_____
____Surgical biopsy	___	___	_____
____Lumpectomy	___	___	_____
____Radiation Therapy	___	___	_____
____Implants (type)	___	___	_____
____Breast Reduction	___	___	_____
____Mastectomy	___	___	_____

Prior Exam to Breast:

Mammogram When? _____ Where? _____

Ultrasound When? _____ Where? _____

MRI When? _____ Where? _____

Please continue to next page

Have you been diagnosed with breast cancer? Yes____ No____ **When**? _____

Is there a history of breast cancer in your family? Yes _____ No_____ If yes, please list below

Relative	Age	Relative	Age
_____	___	_____	___
_____	___	_____	___

Menstrual History:

Are you still menstruating? Yes____ No____
If yes, what was the first day of your last menstrual cycle ___/___/___
Normal cycle length? _____days

Are you currently taking hormones? (birth control, hormone replacement, progesterone) Yes____ No____

If yes, what type of hormone and for how long? _____
If you have in the past, when did you stop?_____

Have you been tested for the BRCA gene? Yes____ No____

If yes what were the results?_____

Are you currently breastfeeding? Yes____ No____

Have you previously been diagnosed for a different cancer? Yes____ No____

If yes when and what type?_____
Did you have radiation or chemotherapy? _____