RADIA®

MRI BREAST QUESTIONNAIRE

Please help us make an accurate diagnosis by answering the following questions:

What is your current weight? _____ (lbs/kgs) What is your height? _____

Reason for exam: ❑ Screening MRI ❑ Recently diagnosed with breast cancer (R____ L_____) ❑ Implant screening

I'm having the following problem(s): ❑ Lump (R____ L_____) ❑ Thickening ❑ Nipple discharge/problem
❑ Implant (R____ L_____) ❑ Enlarged lymph nodes under arm ❑ Other _____

❑ Yes ❑ No Have you had prior breast imaging?
Type of imaging study: _____ When: _____ Name of facility: _____
Type of imaging study: _____ When: _____ Name of facility: _____

❑ Yes ❑ No Do you have a family history of breast cancer?
If yes, who: ❑ Grandmother ❑ Mother ❑ Sister ❑ Other
Age diagnosed: _____ Year diagnosed: _____

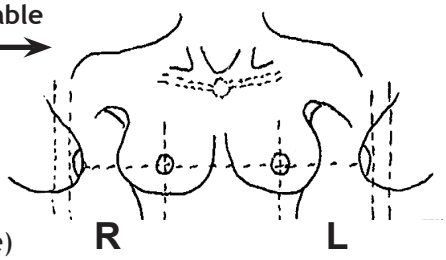
❑ Yes ❑ No Have you ever had cancer? If yes, what type: _____ Age diagnosed: _____

❑ Yes ❑ No Do you currently have pain? Where: _____

❑ Yes ❑ No Have you had radiation or chemotherapy treatment?

BREAST HEALTH HISTORY – **Please include year and location on diagram, if applicable**

❑ Surgical biopsy ❑ Core biopsy (ultrasound or stereotactic)
❑ Lumpectomy (radiation therapy ❑ Yes ❑ No)
❑ Moles on breast ❑ Axillary lymph node dissection (ALND)
❑ Sentinel lymph biopsy (SLN)
❑ Mastectomy ❑ Reduction mammoplasty ❑ Implants (❑ saline ❑ silicone)



For female patients:

❑ Yes ❑ No Are you pregnant? Date of last menstrual period: _____
❑ Yes ❑ No Are you breast feeding?
❑ Yes ❑ No Have you taken oral contraceptives or hormone replacement therapy?
If yes, what type: _____
If you are no longer taking oral contraceptives or HRT, when did you stop: _____

Signature of patient: _____ Date: _____

Name of person filling out this form, if other than the patient (please print): _____

Relationship to patient (please print): _____

Technologist Initials: _____

Affix Pt Sticker Here

(rev 9/15)