OREGON HEALTH & SCIENCE UNIVERSITY
Diagnostic Imaging Services

MRI Breast Imaging Patient Questionnaire

Place Patient Label Here

Please complete this questionnaire in addition to the general MRI Patient Questionnaire

Name: Birth Date:

Primary physician: Surgeon:

Next appointment with your physician or surgeon?

PATIENT HISTORY

☐ Yes ☐ No	Has anyone in your family ever had breast or ovarian cancer? Mother _____ Sister _____ Daughter _____ Aunt _____ Grandmother _____
☐ Yes ☐ No	Have you taken or are you currently taking hormone replacements or birth control pills? If yes, type: When did you stop?
☐ Yes ☐ No	Do you have breast implants?
☐ Yes ☐ No	Are you Currently menstruating? If yes, 1st day of last menstrual cycle: __/__/____

PREVIOUS BIOPSIES OR SURGERY

Needle Biopsy	☐ Right ☐ Left	Date:	Results:
Surgical Biopsy	☐ Right ☐ Left	Date:	Results:
Lumpectomy for Cancer	☐ Right ☐ Left	Date:	Results:
Mastectomy	☐ Right ☐ Left	Date:	Results:
Breast Radiation	☐ Right ☐ Left	Date:	Results:
Breast Reduction	☐ Right ☐ Left	Date:	Results:

REASON FOR EXAM (check all that apply)

☐ Implants
☐ Nipple discharge
☐ Enlarged lymph glands under arm
☐ Personal history of breast cancer
  ☐ Right breast ☐ Left breast
☐ Breast lump
  ☐ Right breast ☐ Left breast

☐ Other:____________________________

____

PLEASE MARK THE LOCATION OF ANY BREAST LUMPS OR SURGERY

R L

Signature of Person Completing Form: ________________________________Date:____________
Relationship to Patient: ☐ Self ☐ Relative ☐ RN ☐ Physician ☐ Other: ______________
Form information reviewed by: ____ Title: _________