MRI BREAST PATIENT QUESTIONNAIRE

Patient Name ______________________________ DOB ____________

Family History of <u>Breast Cancer</u>	**Family History of <u>Ovarian Cancer</u>**	**Family History of <u>Male Breast Cancer</u>**
Relationship / Age Diagnosed	Relationship / Age Diagnosed	Relationship / Age Diagnosed
❑ Mother / ____________	❑ Mother / ____________	____________ / ________
❑ Sister / ____________	❑ Sister / ____________	____________ / ________
❑ Daughter / ____________	❑ Daughter / ____________	____________ / ________

Personal History of Breast Cancer: ❑ YES ❑ NO Age of Diagnosis ______

Genetic Testing: Myself	**Genetic Testing: Family Member**	**Have you recently been vaccinated?**
❑ YES ❑ NO	Relation: ____________	Date: ____________
Type: Results:	**Type: Results:**	Vaccine Type: ____________
BRCA1 ____________	BRCA1 ____________	Right/Left Arm: ____________
BRCA2 ____________	BRCA2 ____________	
Other ____________	Other ____________	

Last Clinical Breast Exam: Where: ____________________

1. Are you still menstruating (having periods)? ❑ YES ❑ NO

   If YES, what is the first day of your last menstruating period? ____________

2. Have you ever had any surgery on your breasts? ❑ YES ❑ NO

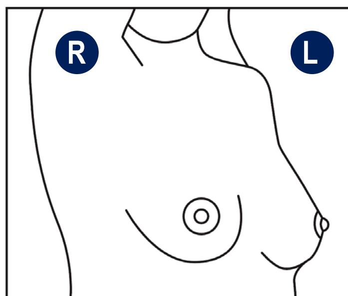
Biopsy	Side: Right / Left	Year: ________	Where ____________
Lumpectomy	Side: Right / Left	Year: ________	Where ____________
Mastectomy	Side: Right / Left	Year: ________	Where ____________
Other	Side: Right / Left	Year: ________	Where ____________
Implants	Side: Right / Left	Year: ________	Type ❑ Silicone ❑ Saline

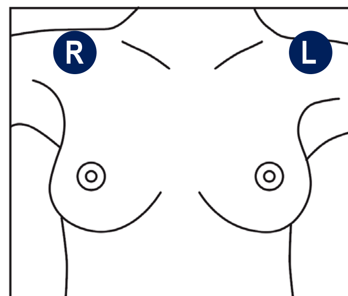
3. Have you had Radiation Therapy to your breast area? ❑ YES ❑ NO

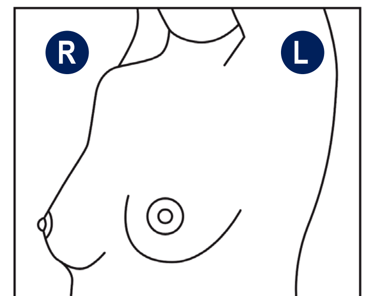
   Side: Right / Left Year: ________

4. ❑ Lump/Pain

MARK THE AREA OF ANY CONCERN ON THE DIAGRAM







Tech Comments ______________________________ Date: ________

Patient Signature ______________________________ Date: ________