Tuba City Regional Health Care Corporation
Radiology Department

MRI Breast Exam Questionnaire

Patient Stamp:

MR#

Name:

DOB:

Patient Age:

Date of Exam: _____

Referring Physician: _____

Clinical History: _____

_____

_____

Breast Evaluation:

Menstrual Status: Start date of last menstrual period: _____

If you are in meopause, since when: _____

Pregnancy Status: Are you currently pregnant: **Yes / No**

Have you been pregnant in the past 6 months (including miscarriage or abortion) **Yes / No**

Are you currently breast feeding/lactating? **Yes / No**

Hormone Replacement Status:

Do you take hormone replacement: **Yes / No**

If yes, which hormone and how long? _____

Do you take Tamoxifen: **Yes / No**

Breast Cancer History:

Have you had breast cancer: Yes / No

If yes, did you have any of the following (please circle):

Surgery **Radiation Therapy** **Chemotherapy**

Breast Biopsy History: Have you had a prior biopsy of the breast: **Yes / No**

If yes, which side and when? _____

Family History of Breast Cancer: **Yes / No**

If yes, who in your family and at what age? _____

Breast Implants: **Yes / No**

If yes, implant type (please circle): **Saline** **Silicone**

Date of Surgery: _____

Silicone Injections: Have you had silicone injected directly in the breast tissue? **Yes / No**

Breast Symptoms: Do you have any pain, discharge or lump: **Yes / No**

Breast Skin: Do you have any scars: **Yes / No**

If yes, where on your breast? _____

Recent Infections: Have you been treated for a breast infection: **Yes / No**

If yes, when? _____

Recent Breast Trauma: In the past 4 months, have you injured your breast: **Yes / No**

Example: Motor vehicle accident with a shoulder restraint. Or a fall.

Patient Signature: _____ Date & Time: _____