

Acct Number: \_\_\_\_\_

# North Fork Radiology, P.C.

## Breast MRI Questionnaire

Today's Date \_\_\_\_\_

Name \_\_\_\_\_  
(last) (first)

What is the reason for today's examination?  
\_\_\_\_\_

1. Date of last menstrual period \_\_\_\_\_

2. Date and place of last mammogram \_\_\_\_\_

3. Date and place of last breast ultrasound \_\_\_\_\_

4. Date and place of last breast MRI \_\_\_\_\_

5. Have you ever had a breast biopsy/surgery? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, which side? Right \_\_\_\_\_ Left \_\_\_\_\_

If yes, what kind? Aspiration \_\_\_\_\_ Core \_\_\_\_\_ Surgical \_\_\_\_\_

6. Do you have a history of breast cancer? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, which side? Right \_\_\_\_\_ Left \_\_\_\_\_

If yes, what treatment have you had? Surgery \_\_\_\_\_

Chemotherapy \_\_\_\_\_

Radiation \_\_\_\_\_

7. Do you have a mother, sister or daughter Yes \_\_\_\_\_ No \_\_\_\_\_

diagnosed with breast cancer?

If yes, was the diagnosis: Before age 50 \_\_\_\_\_ 50 or after \_\_\_\_\_

8. Are you BRCA Gene positive? Yes \_\_\_\_\_ No \_\_\_\_\_ I Don't know \_\_\_\_\_

9. Are you pregnant or nursing? Yes \_\_\_\_\_ No \_\_\_\_\_

10. Any history of hormone therapy? Yes \_\_\_\_\_ No \_\_\_\_\_

(i.e. birth control, replacement, Tamoxifen?) Start \_\_\_\_\_ End \_\_\_\_\_

11. Have you had breast implants inserted? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, what type? Silicone \_\_\_\_\_ Saline \_\_\_\_\_

If yes, how many lumen? Single \_\_\_\_\_ Double \_\_\_\_\_

If yes, when? \_\_\_\_\_

Patient Signature: \_\_\_\_\_