RADNET MANAGEMENT, INC.

Facility: _____

MRI HISTORY FORM

FORM.POL.002
Effective Date: August 1, 2010

MR BREAST HISTORY

Name: _____ Age: _____ Date: _____

Reason for this examination: _____

Have you had a Mammogram/Sonogram before? ☐ Yes ☐ No When: _____ Where: _____

Have you ever had a Breast MRI before? . . . . . ☐ Yes ☐ No When: _____ Where: _____

PHYSICAL CONCERNS			Right	Left	How Long?
Do you feel a lump?	☐ Yes	☐ No			
Is this a new finding?	☐ Yes	☐ No			
Focal or specific point of pain?	☐ Yes	☐ No			
Have you had recent trauma to a breast?	☐ Yes	☐ No			
Nipple discharge or retraction?	☐ Yes	☐ No			
Skin dimpling?	☐ Yes	☐ No			

Additional Information: _____

BREAST SURGICAL HISTORY			Right	Left	Month / Year
Previous breast cancer	☐ Yes	☐ No			/
Mastectomy	☐ Yes	☐ No			/
Lumpectomy (cancer)	☐ Yes	☐ No			/
Radiation therapy	☐ Yes	☐ No			/
Chemotherapy	☐ Yes	☐ No			/
Biopsy (Needle or Surgical)	☐ Yes	☐ No			/
Needle aspiration	☐ Yes	☐ No			/
Reconstruction/Reduction	☐ Yes	☐ No			/
Implants or silicone injections	☐ Yes	☐ No			/

Additional Information: _____

GENERAL HISTORY

Are you pregnant? . . . . . ☐ Yes ☐ No
Breast fed within last 4-6 months . . . . ☐ Yes ☐ No
Any family history of breast cancer? . . ☐ Yes ☐ No
Which relative & age? _____
Have you had any other cancer? . . . . ☐ Yes ☐ No
If yes, what kind? _____
Age at your first full term pregnancy? _____ Yrs

MENSTRUAL HISTORY

1st day of your last period: _____
Menopause? . . . . . ☐ Yes ☐ No
Hysterectomy? . . . . . ☐ Yes ☐ No
Are you taking any hormone
or birth control pills? . . . . ☐ Yes ☐ No
If yes, what kind? _____
If yes, how long? _____

Additional Information: _____

OFFICE USE ONLY

Clinical Findings

Clinical indications/Notes:

_____

_____

_____

_____

Technologist's Name: _____

To the best of my knowledge, all of the above is true and correct.

Patient Signature: _____ Date: _____/_____/_____