UNIVERSITY DIAGNOSTIC MEDICAL IMAGING P.C.

BREAST MRI QUESTIONNAIRE

Acct# _____

NOTE: CARDIAC PACEMAKERS ARE PROHIBITED
AS THEY MAY RESULT IN SERIOUS HARM OR DEATH!

MEDICAL HISTORY: PLEASE FILL OUT COMPLETELY

BREAST HISTORY:

Purpose of Today's Exam: _____

Previous Mammograms: ☐ No ☐ Yes (If yes, fill in below)
When: ____/____/_____ Where: _____ Result: _____

Previous Breast Ultrasound: ☐ No ☐ Yes (If yes, fill in below)
When: ____/____/_____ Where: _____ Result: _____

Previous Breast Mri: ☐ No ☐ Yes (If yes, fill in below)
When: ____/____/_____ Where: _____ Result: _____

Breast History:

My Family History of Breast Cancer: ☐ None ☐ Myself ☐ Mother ☐ Sister ☐ Daughter ☐ _____

My History of Breast Surgery: ☐ None ☐ ___/___/_____ Result _____

The Hormones I Take Now: ☐ None ☐ Birth Control ☐ HRT Other _____

My Last Menstrual Period: ___/___/_____ ☐ More than 5 years ago

Signature: _____ Date: _____

1200 Waters Place, Suite M108 • Bronx, NY 10461 • Tel: (718) 931-5620 • Fax: (718) 824-0706

UNIVERSITY DIAGNOSTIC MEDICAL IMAGING P.C.

BREAST MRI QUESTIONNAIRE

Acct# _____

DATE: _____/_____/_____

NAME: _____ DOB: _____/_____/_____

CURRENT WEIGHT: _____LBS / CURRENT HEIGHT: _____FEET _____INCHES

PLEASE NOTE: CARDIAC PACEMAKERS ARE PROHIBITED
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The following questions must be answered to determine if you qualify to have a MRI

Please describe the problem or reason which necessitated this examination.

_____

Have you ever had a surgical procedure or operation of any kind? ..... **Y / N**
If yes, please list all prior surgeries/dates: _____

- **Cardiac/heart surgery involving**: artificial heart valves, stents, cardiac defibrillator (ICD), or pacemaker? ..... **Y / N**
- **Brain/head, eye or ear surgery in which metallic implants may have been placed** (e.g. aneurysm clips, cochlear (ear) implants, shunt, metal plates or surgical staples)? ..... **Y / N**

Have you ever been injured by any metallic foreign body? (e.g. bullet, BB, shrapnel, etc.)..... **Y / N**
If yes, please describe: _____

Have you ever had an injury to the eye involving a metallic object (e.g. metallic slivers, shavings, foreign body, etc.) Or have you worked as a sheet metal worker? ..... **Y / N**
If yes, please describe: _____

Do you have an artificial or prosthetic limb or a joint replacement (hip, knee, etc.)? ..... **Y / N**
If yes, please describe: _____

Do you have a history of renal disease, seizure, asthma, contrast reactions, or allergies to medication? ..... **Y / N**
If yes, please describe: _____

Do you have a breast tissue expander implant? ..... **Y / N**
If yes, please describe: _____

Do you have any type of electronic, mechanical or metal implant or hearing aid?..... **Y / N**
If yes, please describe: _____

Do you have any history of cancer or tumor? ..... **Y / N**
If yes, please describe: _____

Are you pregnant or do you suspect that you are pregnant?..... **Y / N**

Do you have tattooed eyeliner? ..... **Y / N**
If yes, please inform the technologist prior to the examination.

I attest that the above information is correct to the best of my knowledge. I have read and understand the entire contents of this form and I have had the opportunity to ask questions regarding the information on this form.

Patient's signature _____ Date: ____/____/____

TECH NOTES/ DX (Reserved for MRI technologist use)

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