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MRI QUESTIONNAIRE

MR #:______________

Name:____________________

Age:____________ Date of Birth:____________ Weight:____________

Are you pregnant? Yes_________ No_________ Last Menstrual Period:____________

Using the first day of your menstrual cycle as Day 1, what day are you in today?____________

Referring MD____________________

Do you have renal disease? Yes No Are you diabetic? Yes No

Do you have liver disease? Yes No

If Yes, to either: BUN/Creatinine _____________

Have you had any surgery? Yes_____________ No______________

Please explain:____________________

Do you have a history of breast cancer in your family? (If yes, please indicate the age of diagnosis)

Mother_______ Sister_______ Aunt________ Grandmother_________ Other________________

Have you been diagnosed with the following: (if yes, please indicate when and which breast)

Atypical Ductal Hyperplasia (ADH)	R or L
Invasive breast cancer	R or L
Atypical Lobular Hyperplasia (ALH)	R or L
Multiple papillomas	R or L
Lobular Carcinoma In-Situ	R or L
Positive for BRCA mutations	R or L
Non-Invasive Ductal Carcinoma In-Situ	R or L

Any other cancer (Please explain):____________________

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Have you had any of the following treatments? (If yes, please indicate when and where)

Lumpectomy	R or L	Mastectomy	R or L
Chemotherapy	R or L	Radiation	R or L
Hormone Therapy/Birth Control	Y or N		

Reason for breast MRI today?____________________

When was your last mammogram?__________________

Do you have any breast problems today? (If yes, please indicate which breast)__________

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Breast lump R or L Nipple retraction R or L Breast thickening R or L

Cancer elsewhere______________ Pain/tenderness R or L Nipple discharge R or L
Implant integrity R or L Abnormal mammo/sono R or L
Other:____

Please indicate if you have the following:

Aneurysm clip	Yes__________	No__________
Cardiac Pacemaker	Yes__________	No__________
Implanted cardioverter defibrillator (ICD)	Yes__________	No__________
Electronic implant or device	Yes__________	No__________
Magnetically activated implant or device	Yes__________	No__________
Neurostimulation system	Yes__________	No__________
Spinal cord stimulator	Yes__________	No__________
Internal electrodes or wires	Yes__________	No__________
Bone growth/bone fusion stimulator	Yes__________	No__________
Cochlear otologic or other ear implants	Yes__________	No__________
Insulin or other infusion pump	Yes__________	No__________
Implanted drug infusion device	Yes__________	No__________
Any type of prosthesis	Yes__________	No__________
Heart valve prosthesis	Yes__________	No__________
Eyelid spring or wire	Yes__________	No__________
Artificial or prosthetic limb	Yes__________	No__________
Metallic stent, filter or coil	Yes__________	No__________
Shunt (spinal or intraventricular)	Yes__________	No__________
Vascular access port and/or catheter	Yes__________	No__________
Radiation seeds or implants	Yes__________	No__________
Swan-Ganz or thermodilution catheter	Yes__________	No__________
Medication patch (Nicotine, Nitroglycerin)	Yes__________	No__________
Any metallic fragment or foreign body	Yes__________	No__________
Wire mesh implant	Yes__________	No__________
Tissue expander (e.g. breast)	Yes__________	No__________
Surgical staples, clips or metallic sutures	Yes__________	No__________
Joint replacement (hip, knee, etc.)	Yes__________	No__________
Bone/joint pin, screw, nail, wire, plate, etc.	Yes__________	No__________
IUD, diaphragm or pessary	Yes__________	No__________
Dentures or partial plates	Yes__________	No__________
Tattoo or permanent makeup	Yes__________	No__________
Body piercing jewelry	Yes__________	No__________
Hearing aid	Yes__________	No__________

Other implant____

Please make sure to remove all metal objects. This includes watches, jewelry, keys, hair pins, coins, and cell phones. Please note credit cards and bank cards may be erased in the MRI scan room.
Please consult the MRI technologist or Doctor if you have any questions or concerns BEFORE you enter the MRI system room.

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

Signature of person completing form:____

Date:___________________ Form completed by:____

Form reviewed by: ____

MRI technologist_____________ Physician_____________Other______________________________