Washington Radiology Associates, P.C.

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Place Patient ID label here

Breast MRI Clinical Information

Patient name ____________________ Age ________ ○ Female ○ Male

Reason for exam ____________________ Exam date ________

For female patients only: Date of last menstrual period ____________________

○ Y ○ N Are you nursing?

○ Y ○ N Are you possibly pregnant? (*If yes, notify technologist immediately*)

○ Y ○ N Have you had previous mammograms? If yes, when and where? ____________________

○ Y ○ N Do you have a personal or family history of breast cancer? If yes, please explain: ____________________

Present complaints. *If yes, please indicate right* (R) *or left* (L) *breast.*

		Complaint			Onset of complaint
○ Y	○ N	Lump(s)	○ R	○ L	________
○ Y	○ N	Pain, discomfort, soreness	○ R	○ L	________
○ Y	○ N	Swelling	○ R	○ L	________
○ Y	○ N	Itching	○ R	○ L	________
○ Y	○ N	Nipple retraction	○ R	○ L	________
○ Y	○ N	Nipple discharge/bleeding	○ R	○ L	________
○ Y	○ N	Other ________	○ R	○ L	________

Have you had any of the following breast procedures? *If yes, please indicate right* (R) *or left* (L) *breast.*

		Procedure			When	Results
○ Y	○ N	Needle Aspiration	○ R	○ L	________	________
○ Y	○ N	Biopsy	○ R	○ L	________	________
○ Y	○ N	Resection (i.e., lumpectomy)	○ R	○ L	________	________
○ Y	○ N	Radiation	○ R	○ L	________	________
○ Y	○ N	Chemotherapy	○ R	○ L	________	________
○ Y	○ N	Breast Implants	○ R	○ L	________	(type) ________
○ Y	○ N	Breast Reduction	○ R	○ L	________	________
○ Y	○ N	Mastectomy	○ R	○ L	________	________

○ Y ○ N Do you or have you ever taken birth control pills or hormones such as estrogen, progesterone, thyroid medication or cortisone? If yes, what have you taken and when? ____________________

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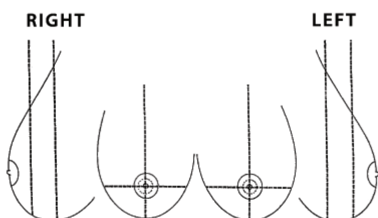

Remarks: ____________________

Technologist: ____________________ Date: ________

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