



For Office Use Only
Place Pt ID label here

Breast MRI Clinical Information

Patient's Name _____ Tech's Init./Exam Date _____ / _____

Age _____ Date of LMP _____

Yes No Are you nursing?

Yes No Are you possibly pregnant? (If yes, notify technologist immediately)

Yes No Have you had previous mammograms? If yes, when and where _____

Yes No Do you have a personal or family history of breast cancer? If yes, please explain _____

Reason for today's exam _____

Present complaints. *Please check those that apply and indicate right or left breast.*

	No	Right Breast	Left Breast	Onset of Complaint
Lump(s)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Pain, discomfort, soreness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Swelling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Itching	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Nipple retraction	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Nipple discharge/bleeding	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Other _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____

Have you had any of the following breast procedures? *Please check those that apply and indicate right or left breast.*

	No	Right Breast	Left Breast	When	Results
Needle Aspiration	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	_____
Biopsy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	_____
Resection (i.e. lumpectomy)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	_____



WASHINGTON
RADIOLOGY
ASSOCIATES, P.C.

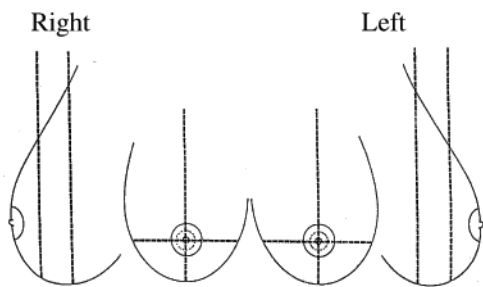
BREAST MRI CLINICAL INFORMATION



	No	Right Breast	Left Breast	When	Results
Radiation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	_____
Chemotherapy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	_____
Breast Implants	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	(Type) _____
Breast Reduction	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	_____
Mastectomy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	_____

Do you or have you ever taken birth control pills or hormones such as estrogen, progesterone, thyroid medication or cortisone? Yes No If yes, what have you taken and when? _____

DO NOT WRITE BELOW THIS LINE



Remarks: _____

