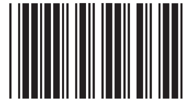
WASHINGTON RADIOLOGY



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Place Patient ID label here

Breast MRI Clinical Information

Patient Name ______________________ Age ________ Exam date ______________

◯ 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. ______________________

◯ Y ◯ N Are you currently taking hormones? If yes, what type? ______________________

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

		Complaint			Onset of complaint
◯ Y	◯ N	Lump(s) or swelling	◯ R	◯ L	________
◯ Y	◯ N	Pain, discomfort, soreness	◯ R	◯ L	________
◯ Y	◯ N	Nipple retraction, discharge or 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	Biopsy	◯ R	◯ L	________	________
◯ Y	◯ N	Resection (i.e., lumpectomy)	◯ R	◯ L	________	________
◯ Y	◯ N	Radiation	◯ R	◯ L	________	________
◯ Y	◯ N	Breast Implants	◯ R	◯ L	________	________
◯ Y	◯ N	Breast Reduction	◯ R	◯ L	________	________
◯ Y	◯ N	Mastectomy	◯ R	◯ L	________	________

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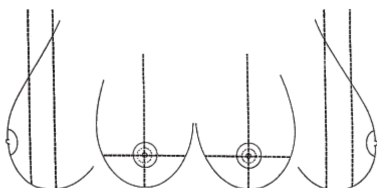

Remarks: ______________________

Technologist: ______________________ Date: ______________

BMRI 1211