BERKSHIRE MEDICAL CENTER
BREAST MRI INFORMATION SHEET

Patient Name _____ DOB: _____

Physician who ordered the MRI: _____

Date and place of prior mammogram: _____

1. Have you had a breast MRI before? YES NO
   If yes, where and when? _____

2. Have you had a breast ultrasound before? YES NO
   If yes, where and when? _____

3. Reason for today's breast MRI? _____

4. Which breast has a problem? RIGHT LEFT

5. Indicate/circle any other breast symptoms: DISCHARGE LUMP PAIN NONE

6. Prior breast biopsy/surgery?

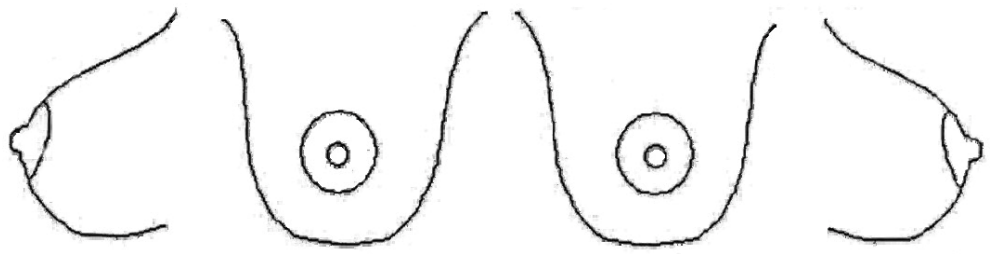
	(circle)		(write in date)
Biopsy	RIGHT	LEFT	_____
Lumpectomy	RIGHT	LEFT	_____
Mastectomy	RIGHT	LEFT	_____
Reduction	RIGHT	LEFT	_____
Implants	RIGHT	LEFT	_____
What type?:	Silicone	Saline (water)	
Reconstructive Surgery	RIGHT	LEFT	_____
What type?:	Tissue	Implant	

7. Have you ever had breast cancer? (circle) YES NO (write in date and side) _____

8. Family history of breast cancer? SELF MOTHER SISTER DAUGHTER NONE

9. Could you be pregnant? YES NO
10. Indicate the start date of your last menstrual period. _____ N/A
11. Do you use estrogen hormones? YES NO

TECHNOLOGIST USE ONLY: Lump-Redness-Thickening-Nipple Retraction-Scar-Skin lesion



Patient Signature:_____ Date:_____ rev (08/10)