

BREAST MRI
BREAST MRI OF OKLAHOMA, LLC **DATE:** _____

NAME _____ Date of Birth _____ Age _____
 Last First Middle

Address: _____ Phone: Home _____ Other _____

Sex: Female Male Height _____ Weight _____

MENSTRUAL HISTORY:

Are you or could you be pregnant? Yes No
 Date of last period _____ Day of Menstrual Cycle _____
 (First day of bleeding is Day 1)
 Do you take Birth Control Pills Yes No
 Do you take hormones? Yes No What Kind? _____

CURRENT BREAST COMPLAINTS:

Lump Right Left Nipple Secretion Right Left Spontaneous? Yes No
 Pain Right Left Infection Right Left
 Abnormal Mammogram/Ultrasound Please Explain _____
 Other _____

PERSONAL BREAST HISTORY:

INVASIVE CANCER? Yes No	NONINVASIVE CANCER? Yes No
Invasive Ductal Carcinoma Right Left	DCIS (Ductal Carcinoma in Situ- aka Intraductal carcinoma) Right Left
Invasive Lobular Carcinoma Right Left	Other _____ Right Left
Medullary, Tubular, Other Right Left	
Other _____ Right Left	

PREMALIGNANT BREAST LESION? Yes No

LCIS (Lobular Carcinoma in Situ) Right Left
 Atypical Ductal Hyperplasia (ADH) Right Left
 Other _____ Right Left

BENIGN? Yes No

Fibroadenoma Right Left
 Breast Cysts Right Left
 Papilloma Right Left

OTHER SIGNIFICANT PERSONAL HISTORY

Have you ever been evaluated for an alteration in the BRCA gene? Yes No
 If "yes" can we contact you regarding the results? Yes No
 Ovarian Cancer Yes No DES? Yes No

FAMILY HISTORY OF BREAST OR OVARIAN CANCER? Yes No

Mother Age at Diagnosis _____ What kind? _____
 Sister Age at Diagnosis _____ What kind? _____
 Daughter Age at Diagnosis _____ What kind? _____
 Other Relation _____ Mother's Side ___ Father's Side ___ Age at Diagnosis _____
 Any Family Members BRCA Gene positive? Yes No

HAVE YOU EVER HAD ANY OF THE FOLLOWING BREAST TREATMENTS? Yes No

Needle Biopsy Right Left Date _____ Segmental Resection for Cancer Right Left Dates _____
 Surgical Biopsy Right Left Date _____ Mastectomy Right Left Dates _____
 Cyst Drainage Right Left Date _____ Radiation Therapy Right Left Dates _____
 Breast Reduction/Lift Right Left Date _____
 Breast Implants Right (Silicone Saline Both) Left (Silicone Saline Both) Date _____

HAVE YOU EVER HAD CHEMOTHERAPY? Yes No Date _____

Are you on Tamoxifen? Yes No Are you on Steroids? (Prednisone etc.) Yes No
 Other? _____

ARE YOU ALLERGIC TO ANYTHING: _____

REFERRING PHYSICIAN/OTHER PHYSICIANS YOU DESIRE TO HAVE A COPY OF THIS REPORT:

Name _____	Name _____
Address _____	Address _____
Phone _____	Phone _____

DID YOU BRING YOUR MAMMOGRAMS, ULTRASOUNDS, PATHOLOGY REPORTS OR OTHER X-RAYS? Yes No

If you did not, have they been sent? Yes No Where were they performed? _____
 May we have your permission to send for them? Yes No Signature _____