



MRI BREAST Patient History Form

**This section to be filled out by scheduler or front office staff Scheduling Initials _____ Front Office Initials _____

MR# _____ Name _____ DOB _____ Weight _____ Height _____

Appointment Date: _____ Time _____ Ordering Physician _____

Area of Interest **MRI of Breast** Contrast **Y or N** (Please Circle)

Diagnosis: _____

_____ STAT _____ Call _____ Fax _____

Important:Previous exams such as mammo, ultrasound or MRI needed before today's exam can be read.**

Patient History-This portion is to be filled out by the patient. Thank you.

Patient (please describe type of symptoms you are having and how long you have been having them)

History of Breast Biopsy or other Surgery?

Type- _____ Date- _____

Type- _____ Date- _____

History Of Breast Cancer: Y or N (Please Circle)

Type- _____ Treatment- _____

Side and Location **Right or Left** (Please Circle) _____

Have you had a Mammogram? **Y or N** (Please Circle)

Did you bring your prior mammo films? Y or N (Please Circle) **If no, please list location where your mammo can be located and retrieved from** _____

Important Note to Patient: *To avoid any delays in receiving the results of your MRI of the Breast- please provide us with location of previous Mammo, Ultrasound or MRI of the Breast. Thank You*

WARNING: Certain implants, devices, or objects may be hazardous to your and/or may interfere with the MR procedure. **Do not enter** the MR system room or MR environment if you have any question or concern regarding an implant, device, or object. **The MR system magnet is ALWAYS on. Items such as credit cards, cell phones, hair pins, barrettes, keys, hearing aids, jewelry, watches, pens, pencils, cigarette lighters, pocket knives, (anything with metal) should not be taken into the MRI room.** Consult the MRI Technologist BEFORE entering the MR system room or if you have any questions.

The Following items may be hazardous to your safety or may interfere with the MRI exam. Please read carefully and check if you have any of the following:

- | | |
|--|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cardiac Pacemaker/Defibrillator | <input type="checkbox"/> Yes <input type="checkbox"/> No Tattoos |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Aneurysm Clips | <input type="checkbox"/> Yes <input type="checkbox"/> No Neurostimulator |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cardiac STENTS | <input type="checkbox"/> Yes <input type="checkbox"/> No Shunt |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Pacemaker Wires | <input type="checkbox"/> Yes <input type="checkbox"/> No Vascular Port |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Ear Implants/Cochlear Implants | <input type="checkbox"/> Yes <input type="checkbox"/> No Artificial limb/joint |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Implanted Insulin Device | <input type="checkbox"/> Yes <input type="checkbox"/> No Bullet, bb's, shrapnel |
| <input type="checkbox"/> Yes <input type="checkbox"/> No History of Liver Transplant | <input type="checkbox"/> Yes <input type="checkbox"/> No Metal fragments in eyes |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Valve Prosthesis | <input type="checkbox"/> Yes <input type="checkbox"/> No Orthopedic Implants |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Orbital/Eye Prosthesis | <input type="checkbox"/> Yes <input type="checkbox"/> No Penile Implant |
| <input type="checkbox"/> Yes <input type="checkbox"/> No IUD/Contraceptive | <input type="checkbox"/> Yes <input type="checkbox"/> No Bio stimulator |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Any History of Kidney Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No Hearing Aids |

As a part of your scan we may need to inject you with a contrast solution which will highlight the images to provide important diagnostic information. During the injection, you may feel a cool or warm sensation near the injection site or experience a slight metallic taste, which will dissipate after the injection is completed. Although rare, an adverse reaction can occur. In very rare cases, this could be severe.

(Print Name)

(Signature of Patient/Parent/Guardian)

(Date)

WOMEN ONLY

Is there any possibility that you may be pregnant? No Yes Are you nursing? No Yes

MRI CONSENT FOR PREGNANCY

Risk of MRI studies in early stages of pregnancy is unknown. I recognize that my ordering physician feels the need for the examination outweighs any unknown risk.

(Print Name)

(Signature of Patient/Parent/Guardian)

(Date)

Technologist Signature

Date