MedStar Georgetown University Hospital

Betty Lou Ourisman Breast Health Center

BREAST MRI PATIENT HISTORY FORM

Arrival Time _____

Appointment Time _____

Name: _____ **Date of Birth:** ___/___/___

Patient Daytime Telephone Number _____ Cell Phone Number _____

Please describe the reason your doctor ordered this study: _____

_____

When was the first day of your last menstrual period? _____ ❑ Post menopausal

❑ No **Is this your first MRI? If no, when and where did you have your last MRI?** ❑ Yes

____ (month) ____ (year) Facility Name _____

Facility City / State _____

Describe Results _____

❑ No **Have you had a prior mammogram or ultrasound?** ❑ Yes

____ (month) ____ (year) Facility Name _____

Facility City / State _____

Describe Results _____

Have these been submitted? ❑ No ❑ Yes

❑ No **Did you bring any comparison imaging exams with you (MRI's, mammogram, ultrasound) today or have they been previously submitted?** ❑ Yes

❑ No **Do you have a family history of breast cancer? If yes, please indicate in which relative and age at diagnosis** ❑ Yes

❑ Mother ____ ❑ Father ____ ❑ Sister ____ ❑ Daughter ____ ❑ Grandmother ____

❑ No **To the best of your knowledge are you pregnant?** ❑ Yes

❑ No **Have you been diagnosed with cancer other than breast? If yes, type of cancer and year.** ❑ Yes

Please specify: _____

❑ No **Have you ever been diagnosed or treated for breast cancer? If yes, which procedure and breast?** ❑ Yes

❑ Mastectomy ❑ Rt ❑ Lt Date: _____

❑ Lumpectomy ❑ Rt ❑ Lt Date: _____

❑ Radiation ❑ Rt ❑ Lt Date: _____

❑ Chemotherapy Date: _____

❑ Tamoxifen Date: _____

❑ No **Have you had any other type of breast surgery? If yes, what?** ❑ Yes

❑ Implants ❑ Rt ❑ Lt Date: _____ ❑ saline ❑ silicone

❑ Reduction ❑ Rt ❑ Lt Date: _____

❑ Biopsy ❑ Rt ❑ Lt Date: _____

❑ Other: _____ Date: _____

❑ No **Are you taking any hormone medications?** ❑ Yes

If yes, name of hormone: _____ .

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❑ No **Are you currently having any breast problems? If yes, what kind?** ❑ Yes

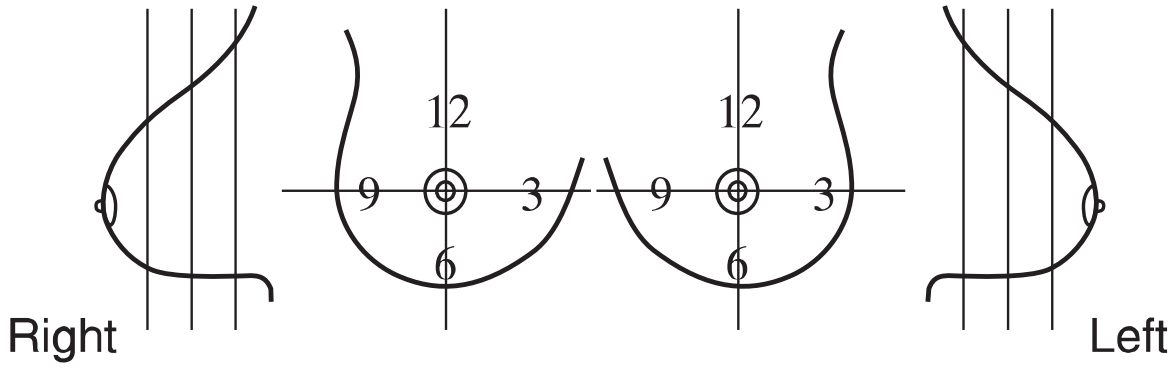
Right	Left	
❑	❑	I feel a NEW lump, mass, or thickening
❑	❑	My physician feels a NEW lump, mass, or thickening
❑	❑	NEW nipple discharge ❑ clear ❑ bloody ❑ other
❑	❑	Focal Pain
❑	❑	Other: _____

❑ No **Is this a follow up to a previously abnormal mammogram or ultrasound?** ❑ Yes

Please specify: _____

Patient Signature_____Date_____Time_____

FOR TECHNOLOGIST USE ONLY



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The patient has been informed to submit prior exams for comparison ❑ Yes Tech Initials _____