

**MRI Breast Questionnaire**

Name: \_\_\_\_\_ D.O.B. \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Sex: M/F WT: \_\_\_\_\_ lbs

**YES**  **NO**  **Have you received a COVID vaccine? If yes, please answer the following: Pfizer/Moderna/J&J**  
**1<sup>st</sup> dose date:** \_\_\_\_\_ **Arm: RIGHT / LEFT** **2<sup>nd</sup> dose date:** \_\_\_\_\_ **Arm: RIGHT / LEFT**

Why are you having the exam? (Symptom): \_\_\_\_\_

What side, location, body part is involved? (Location): \_\_\_\_\_

How long have you had this problem? (Duration): \_\_\_\_\_

If due to injury, how did it occur? (Mechanism of Injury): \_\_\_\_\_

YES  NO  Have you ever had a reaction to MRI contrast?

YES  NO  Is there any chance you may be pregnant? Date of last menstrual period? \_\_\_\_\_

YES  NO  Do you wear a Dexcom, Libre, or other glucose monitor? \_\_\_\_\_

YES  NO  Any prior surgery of the area? Type/dates? \_\_\_\_\_

YES  NO  Any radiation therapy? If YES, dates? \_\_\_\_\_

YES  NO  Any chemotherapy? If YES, dates? \_\_\_\_\_

YES  NO  Did you have any prior imaging of the area being scanned in another imaging facility?  
Where/when? \_\_\_\_\_

YES  NO  Do you use hormone replacement therapy? If yes, for how long? \_\_\_\_\_

YES  NO  Have your ovaries been removed? If yes: when: \_\_\_\_\_

YES  NO  Do you have breast implants? If yes, (please circle one) Saline    Silicone

YES  NO  Are you in a lung cancer screening program with yearly CTs of the chest?

YES  NO  Do you now or have you ever smoked?

If **YES**, how many years did you smoke? \_\_\_\_\_ years

How many packs per day did you smoke? \_\_\_\_\_ packs per day

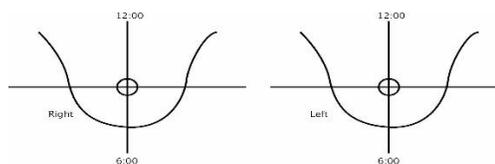
How long ago did you quit? If still smoking, mark as "0": \_\_\_\_\_ years ago

**I acknowledge that all the information given is accurate and thereby consent to have MRI with or without an injection of contrast performed on me. I do not have a pacemaker. I have removed all hearing aids, dentures, external pumps and monitoring devices.**

Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Technologist Notes: \_\_\_\_\_

**Please diagram scars or physical findings:**



Technologist Initials: \_\_\_\_\_