

First Name _____ Last Name _____ DOB/Age _____
 Ht. _____ Wt. _____ Allergies _____ PT# (Internal) _____

REASON FOR EXAM (Please include symptoms and time frame):

TECH NOTES (for internal use only):
Sedation: _____
MRI Safety: _____

Guerbet Dotarem Contrast:
 _____ from _____ vial

Previous Imaging Studies Related to Todays Exam	Date
Previous Surgeries Related to Todays Exam	Date

Additional Notes:

Current Symptoms (Check all that apply) **How long?**

Breast tenderness/Pain Yes No Right Left _____

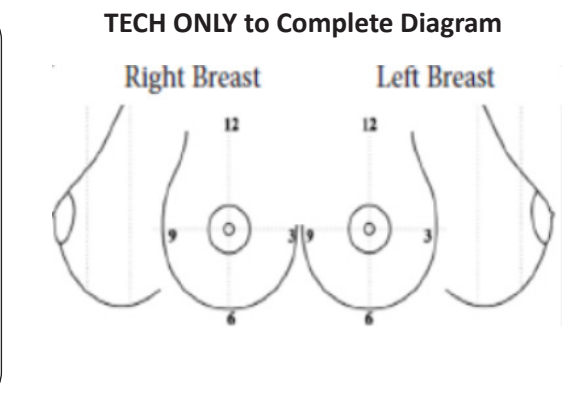
Lumps Yes No Right Left _____

Nipple Discharge Yes No Right Left _____

If yes to above, color: _____

Nipple Retraction Yes No Right Left _____

Skin Dimpling Yes No Right Left _____



Are you still having menstrual periods? Yes No Date of last period: _____

Have you ever been pregnant? Yes No Age of first pregnancy/birth: _____

Are you taking hormones or birth control? Yes No Type/how long: _____

Do you have breast implants? Yes No Saline Silicone Date Implanted: _____

Are you a smoker? Yes No Did you get the COVID Vaccine? Yes No

Side of COVID Vaccine Injection(s): Right Left Both Date of last injection: _____

Have you ever been tested for the BRCA Gene? Yes No If Yes, please indicate results below:
 BRCA 1: POS NEG BRCA 2: POS NEG Do you have a family history of breast cancer? Yes No
 If yes, which family member(s): Mother Grandmother Sister Daughter Other _____
 Do you have a personal history of breast cancer? Yes No If yes, date of diagnosis: _____
 What type of breast cancer? _____ Location: _____
 Has it spread? Yes No If yes, where? _____
 Current status: Newly Diagnosed Recurrence Remission
 Treatment(s): ChemoTherapy Surgery Radiation Tamoxifen Armidex Other _____
 Date of last treatment: _____ Is your visit today related to the above cancer diagnosis? Yes No

I agree that the above information is correct (Do not fill out until after technologist has reviewed):
 Patient Signature: _____ Today's Date: _____