SDMI STEINBERG DIAGNOSTIC

INTAKE QUESTIONNAIRE MRI BREAST IMAGING

First Name _____ Last Name _____ DOB/Age _____

Allergies/Include reaction(s) _____.

Height _____ Weight _____ Patient# (*Internal Use Only*) _____

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

Previous Imaging Studies Related to Todays Exam	Date

Previous Surgeries Related to Todays Exam	Date

TECH NOTES *(for internal use only)*:

Sedation:	
MRI Safety:	

Guerbet Dotarem Contrast:

_____ from _____ **vial**

Additional Notes:

Current Symptoms (Check all that apply) How long?

Breast tenderness/Pain ☐ Yes ☐ No ☐ Right ☐ Left _____

Lumps ☐ Yes ☐ No ☐ Right ☐ Left _____

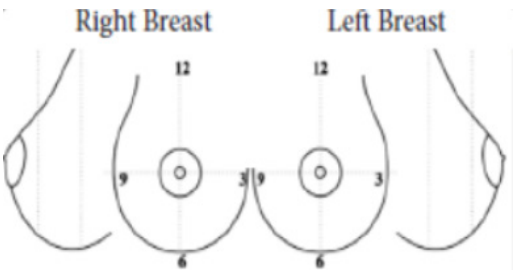
Nipple Discharge ☐ Yes ☐ No ☐ Right ☐ Left _____

If yes to above, color: _____

Nipple Retraction ☐ Yes ☐ No ☐ Right ☐ Left _____

Skin Dimpling ☐ Yes ☐ No ☐ Right ☐ Left _____

TECH ONLY to Complete Diagram



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: _____ Todays Date: _____