# SRS MRI BREAST History Form

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Name: DOB: Sex:

Last, First

Referring MD: Exam: Date Of Service:

## MRI BREAST HISTORY

1. Last Menstrual Period: _____

Age period started:_____ Age at birth of first child:_____ Age period stopped:_____

2. Prior Mammograms? Y N If yes, where and when?_____

3. Family history breast cancer? Y N If yes, who? _____

**CIRCLE CORRECT ANSWER**

4. Have you been previously diagnosed with breast cancer? Y N Which breast? R L Both

5. Have you had prior breast surgery? Y N

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Biopsy | Y | N | R | L | Both | When?_____ | Where?_____ |
| Implants | Y | N | R | L | Both | When?_____ | Where?_____ |
| Reduction | Y | N | R | L | Both | When?_____ | Where?_____ |
| Lumpectomy | Y | N | R | L | Both | When?_____ | Where?_____ |

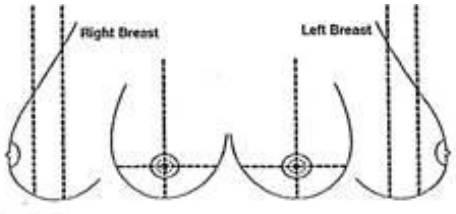
6. Do you have any breast skin abnormality? Y N A) Moles____ R L Both
B) Scars____ R L Both

7. Do you currently have: A) Breast Lump? Y N R L Both
B) Nipple Discharge Y N R L Both

8. Do you currently take hormonal replacement? Y N

**TechnologistNotes:**_____

_____




Patient Signature: _____