BREAST MRI SCREENING FORM

Name: ______________________________ **Ref. Physician:** ___________________________________

Reason for exam: ____

Date of Last Mammogram: ________________________ **Location:** ___________________________

Date of Last Breast Sonogram: ____________________ **Location:** ___________________________

Date of Last Breast MRI: __________________________**Location:** ____________________________

Date of Last Menstrual Period: __________________ **Weight:** _________

Allergies: ____

Do you have breast implants: Yes No

If yes, what type: Saline/water silicone both

Having any problems with implants? Yes No

History of Breast Biopsy: Yes No **Which side:** Lt Rt Both

If yes, type: Surgical or Image Guided (done in radiology)

When: _________________ Where: __________________

Surgeon: ____

History of Breast Cancer: Yes No **Which side:** Lt Rt Both

If yes, type: ____________________ Date of Diagnosis: _______________

History of Radiation: Yes No **Which side:** Lt Rt Both

Date of last Radiation treatment: ____________________

Family history of breast cancer: Yes No

If yes, relationship: ___________________________

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Previous surgery: ____

Diagnosed with other cancer: ____

Kidney Disease **Y N** ***Sickle cell anemia*** **Y N** ***BP meds*** **Y N** ***Diabetes*** **Y N**

transplant or pending

Serum creatinine ____________ **G.F.R. (*MDRD*)** ______________

MRI approved by Dr. (if < 30 GFR) ____

_______ **CC/ML of** _________ **Dotarem** Injection site: _________ Attempts _____________

_________ **Gadavist** Person started IV: ____________________________

IV D/C ______________ AM PM

Tech Signature _________________________ Date ___________________ Time _________ AM PM

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