WASHINGTON RADIOLOGY

Breast MRI Clinical Information

For Office Use Only
Place Patient ID label here

Patient Name _____ Age _____ ◯ Female ◯ Male

Exam Type _____ Today's Date: _____

◯ **Y** ◯ **N** Have you had previous mammograms? If yes, when and where? _____

_____

_____

◯ **Y** ◯ **N** To the best of your knowledge, are you pregnant? Date of last period: _____ ◯ Postmenopausal

◯ **Y** ◯ **N** Do you have a history of breast cancer or other serious illness? If yes, please explain

_____

_____

◯ **Y** ◯ **N** Has anyone in your family had breast cancer? If yes, please explain

_____

◯ **Y** ◯ **N** Are you currently taking hormones? If yes, what type? _____

◯ **Y** ◯ **N** Have you had a vaccine in the past 4 months? If yes (circle): Covid, Other, Covid and other, Not Sure

Which arm was/were the vaccine(s) administered? Left Right Not Sure Other

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Present complaints. *If yes, please indicate right (R) or left (L) breast.* Onset of complaint

◯ **Y** ◯ **N** Lump(s) or swelling ◯ **R** ◯ **L** _____

◯ **Y** ◯ **N** Pain, discomfort, soreness ◯ **R** ◯ **L** _____

◯ **Y** ◯ **N** Nipple retraction, discharge or bleeding ◯ **R** ◯ **L** _____

◯ **Y** ◯ **N** Other _____ ◯ **R** ◯ **L** _____

Have you had any of the following breast procedures? *If yes, please indicate right (R) or left (L) breast.*

◯ **Y** ◯ **N** Biopsy ◯ **R** ◯ **L**

◯ **Y** ◯ **N** Resection (i.e. lumpectomy) ◯ **R** ◯ **L**

◯ **Y** ◯ **N** Radiation ◯ **R** ◯ **L**

◯ **Y** ◯ **N** Breast Implants ◯ **R** ◯ **L**

◯ **Y** ◯ **N** Breast Reduction ◯ **R** ◯ **L**

◯ **Y** ◯ **N** Mastectomy ◯ **R** ◯ **L**

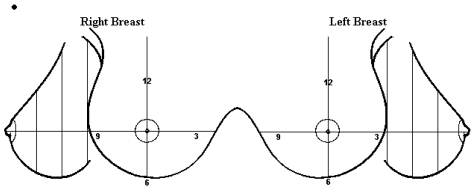
Our records indicate you have had the following procedures:

PROCEDURE	SIDE	DATE

Patient Signature _____ **Date** _____

FOR OFFICE USE ONLY

RIGHT LEFT



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Technologist: _____ Date: _____