ChristianaCare

ENCBASFRM

Breast Center

BREAST MAGNETIC RESONANCE IMAGING (MRI) QUESTIONNAIRE

Instruction:
To be completed by patient prior to MRI imaging.

Weight: _____ lbs. Height: _____ ' _____"

Reason for MRI and/or symptoms: _____

_____

_____

Referring/ordering physician: _____

Other physician needing reports: _____

WARNING: Certain implants, devices or objects may be hazardous to you and/or may interfere with the MRI procedure. Do not enter the MRI system room or MRI environment if you have any question or concern regarding an implant, device, or object. Consult the MRI Technologist BEFORE entering the MRI room. The MRI Magnet is ALWAYS on.

Do you have, or have you had any of the following:

☐ Yes ☐ No	Cardiac pacemaker	☐ Yes ☐ No	Vascular access port and/or catheter
☐ Yes ☐ No	Aneurysm clip(s)	☐ Yes ☐ No	Radiation seeds or implants
☐ Yes ☐ No	Implanted cardioverter defibrillator (ICD)	☐ Yes ☐ No	Swan-Ganz or thermodilution catheter
☐ Yes ☐ No	Electronic implant or device	☐ Yes ☐ No	Skin patch (e.g., Nicotine, Nitroglycerine, pain)
☐ Yes ☐ No	Magnetically-activated implant or device	☐ Yes ☐ No	Any metallic fragment or foreign body
☐ Yes ☐ No	Neurostimulation system	☐ Yes ☐ No	Wire mesh implant
☐ Yes ☐ No	Spinal cord stimulator	☐ Yes ☐ No	Tissue expander (e.g., breast)
☐ Yes ☐ No	Internal electrodes or wires	☐ Yes ☐ No	Surgical staples, clips, or metallic sutures
☐ Yes ☐ No	Bone growth/bone fusion stimulator	☐ Yes ☐ No	Joint replacement (e.g., hip, knee)
☐ Yes ☐ No	Cochlear, otologic, or other ear implant	☐ Yes ☐ No	Bone/joint pin, screw, nail, wire, plate
☐ Yes ☐ No	Insulin or other infusion pump	☐ Yes ☐ No	IUD, diaphragm, or pessary
☐ Yes ☐ No	Implanted drug infusion device	☐ Yes ☐ No	Dentures, or partial plates
☐ Yes ☐ No	Any type of prosthesis (e.g., eye, penile)	☐ Yes ☐ No	Tattoo or permanent makeup
☐ Yes ☐ No	Heart valve prosthesis	☐ Yes ☐ No	Body piercing jewelry
☐ Yes ☐ No	Eyelid spring or wire	☐ Yes ☐ No	Hearing aid
☐ Yes ☐ No	Artificial or prosthetic limb	☐ Yes ☐ No	Other implant: _____
☐ Yes ☐ No	Metallic stent, filter, or coil	☐ Yes ☐ No	Breathing problem or motion disorder
☐ Yes ☐ No	Shunt (e.g., spinal, intraventricular)	☐ Yes ☐ No	Claustrophobia

1. Have you had prior surgery or an operation (e.g., arthroscopy, endoscopy) of any kind?
   ☐ No ☐ Yes, please indicate the date and type of surgery:
   Date: _____ /_____ /_____ Type of surgery: _____
   Date: _____ /_____ /_____ Type of surgery: _____

2. Mammogram: ☐ No ☐ Yes Date: _____ /_____ /_____ Where: _____
   Breast Ultrasound: ☐ No ☐ Yes Date: _____ /_____ /_____ Where: _____
   Breast MRI: ☐ No ☐ Yes Date: _____ /_____ /_____ Where: _____

3. Have you ever done any sheet metal/welding work? ☐ Yes ☐ No

4. Have you had an injury to the eye involving a metallic object or fragment (e.g., metallic slivers, shavings, foreign body, etc.)? ☐ No ☐ Yes, describe: _____

5. Have you ever been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel, etc.)?
   ☐ No ☐ Yes, describe: _____

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Weight: _____ lbs. Height: _____ ' _____"

6. Have you ever taken hormone replacement therapy? ☐ No ☐ Yes
7. When was the first day of your last menstrual period? _____ /_____ /_____
8. Have your menstrual periods stopped permanently? ☐ No ☐ Yes: ☐ stopped naturally ☐ stopped due to surgery
9. Are you currently pregnant? ☐ No ☐ Yes
10. Are you currently breast feeding? ☐ No ☐ Yes
11. Are you allergic to any medications?
    ☐ No ☐ Yes, list and describe reaction: _____
12. Do you have a history of asthma, allergic reaction, respiratory disease, or reaction to a contrast medium or dye used for an MRI, CT, or X-ray examination? ☐ No ☐ Yes, describe: _____
13. Do you have anemia or any disease(s) that affects your blood, a history of kidney disease, kidney failure, kidney transplant, high blood pressure (hypertension), liver disease, a history of diabetes, or seizures?
    ☐ No ☐ Yes, describe: _____

HAVE YOU HAD ANY OF THE FOLLOWING (list results, if known)?	**Left**	**Right**
Fine needle aspiration or cyst aspiration: Date: _____ /_____ /_____ Result: _____	☐	☐
Needle or core biopsy (stereotactic or ultrasound guidance): Date: _____ /_____ /_____ Result: _____	☐	☐
Surgical excisional biopsy: Date: _____ /_____ /_____ Result: _____	☐	☐
Lumpectomy for breast cancer: Date: _____ /_____ /_____ Result: _____	☐	☐
Mastectomy reconstruction? ☐ No ☐ Yes Date: _____ /_____ /_____	☐	☐
Breast plastic surgery: ☐ No ☐ Yes, type: ☐ Lift ☐ Reduction ☐ Saline implants ☐ Silicone implants	☐	☐

IF YOU HAVE BEEN TOLD YOU HAVE BREAST CANCER, PLEASE INDICATE TREATMENT

☐ Radiation to breast or chest Date: _____ /_____ /_____
☐ Chemotherapy Date: _____ /_____ /_____
☐ Lymph node sampling Date: _____ /_____ /_____

HAVE YOU EVER BEEN DIAGNOSED WITH ANY OTHER TYPE OF CANCER (other than breast cancer)?

☐ No ☐ Yes, indicate type(s) and age at diagnosis:
Type: _____ Age: _____ Type _____ Age: _____

FAMILY HISTORY

Have any of your **BLOOD** relatives (mother, sister, daughter) been diagnosed with breast cancer?
☐ No ☐ Yes, list who and age of diagnosis:
Relationship: _____ Age: _____ Relationship: _____ Age: _____

_____ _____ ___/___/___ _____
Signature of Patient or Representative | Print Name and Relationship to Patient if Applicable | Date | Time

Interpretation: The information has been presented to the: ☐ Patient ☐ Representative ☐ Decision Maker in: _____ Language
The person who provided the interpretation is a qualified medical interpreter.

_____ _____
Interpreter Name | Agency and ID# (if applicable)

_____ _____ ___/___/___ _____
Witness Signature/Title | Print Name or ID# | Date | Time