MRI Breast Safety Screening Questionnaire

Name:_____ Date of Birth:_____ Height:_____

Referring Provider:_____ Date of Exam:_____ Weight:_____

Do you have **ANY** of the following? Please answer **ALL** questions.

Yes	No	Cardiac pacemaker	Yes	No	Allergy or reaction to MR contrast *(gadolinium)*
Yes	No	Implanted cardioverter defibrillator (*ICD*)	Yes	No	Vascular access port
Yes	No	Internal electrodes or wires	Yes	No	Swan-Ganz thermodilution catheter
Yes	No	Heart valve prosthesis	Yes	No	Radiation seeds or implants
Yes	No	Cardiac or vascular stent, filter, coil	Yes	No	Medication Patch
Yes	No	Aneurysm clips	Yes	No	IUD, diaphragm, pessary
Yes	No	Neurostimulation system *(or past removal of one)*	Yes	No	Joint replacement (*e.g. hip, knee*)
Yes	No	Spinal cord stimulator	Yes	No	Orthopedic pin, screw, plate, etc.
Yes	No	Shunt (*spinal or intraventricular*)	Yes	No	Surgical staples, clips, metallic sutures
Yes	No	Bone growth or electronic fusion stimulator	Yes	No	Wire mesh implant
Yes	No	Implanted drug infusion device	Yes	No	Any other implants not directly queried
Yes	No	Tissue Expander (*e.g. breast expander*)	Yes	No	Kidney disease or renal insufficiency
Yes	No	Any type of prosthesis (*eye, penile, limb, etc.*)	Yes	No	Diabetic, hypertension, liver disease
Yes	No	Pill cam capsule endoscopy device	Yes	No	Breathing problems or motion disorder
Yes	No	Cochlear, otologic, other ear implants	Yes	No	Tattoo or permanent make-up (Minimum 2 weeks since date of tattooing before patient can be scanned)
Yes	No	Hearing aids (*must remove before entering MRI room*)	Yes	No	Body piercing jewelry
Yes	No	Eyelid spring or wire	Yes	No	Dentures or partial plates
Yes	No	Eye surgery (*cataracts, lens replacements, etc.*)	Yes	No	Are you claustrophobic?
Yes	No	Injury to eye by metallic object	*Staff Use Only*:_____		
Yes	No	Metallic fragments or particles in eyes	_____		
Yes	No	Metallic fragments removed by a physician?	_____		
Yes	No	Any metal fragment, shrapnel, bullet, foreign body	_____		
Yes	No	Are you pregnant?	_____		
Yes	No	Myasthenia gravis? *(should not use MRI contrast if yes)*			

IMPORTANT!!! – For your safety, you are required to change into the gown(s) provided for your exam.

Before entering the MR environment or MR system room, you must remove ALL metallic objects including, hearing aids, dentures, partial plates, keys, beepers, cell phone, eyeglasses, hair pins, barrettes, jewelry, body piercing jewelry, watch, safety pins, paperclips, money clips, credit cards, bank cards, magnetic strip cards, coins, pens, pocketknife, nail clippers, tools.

I attest that the above information is correct to the best of my knowledge. I have read and understand the contents of this form and have had the opportunity to ask questions regarding the MR procedure that I am about to undergo.

Form Completed By: _____ Signature: _____

Relationship to Patient: _____ Date: _____

Patient Initials _____ I have been given a copy of a gadolinium medication guide for my review.

Staff Use Only:

Reviewed By: Staff: _____ Date: _____ Staff: _____ Date: _____

(719)
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MRI Breast Questionnaire

Patient Name: _____ Date: _____

Did you give birth prior to age 30?	Yes	No
Do you have breast implants?	Yes	No
Have you had a previous mammogram?	Yes	No
Where? _____	When? _____	
Have you had a previous breast ultrasound or breast MRI?	Yes	No
Where? _____	When? _____	
Family History of breast Cancer	Yes	No
Who? _____	Age? _____	

Personal Breast History

Biopsy Right No Yes How Many? _____

Most Recent Biopsy Date: _____

Benign	No	Yes	If Yes, Date_____
Malignant	No	Yes	If Yes, Date_____
Mastectomy	No	Yes	If Yes, Date_____
Lumpectomy	No	Yes	If Yes, Date_____
Radiation	No	Yes	If Yes, Date_____
Chemo	No	Yes	If Yes, Date_____
Other	No	Yes	If Yes, Date_____

Biopsy Left No Yes How Many? _____

Most Recent Biopsy Date: _____

Benign	No	Yes	If Yes, Date_____
Malignant	No	Yes	If Yes, Date_____
Mastectomy	No	Yes	If Yes, Date_____
Lumpectomy	No	Yes	If Yes, Date_____
Radiation	No	Yes	If Yes, Date_____
Chemo	No	Yes	If Yes, Date_____
Other	No	Yes	If Yes, Date_____

Has Your Cancer Treatment Ended? No Yes If Yes, Date_____

Taking Hormones? Yes No Date Started: _____ Date Stopped: _____

Start date of last normal menstrual cycle: _____

Taking birth control pills? Yes No If yes, how long? _____

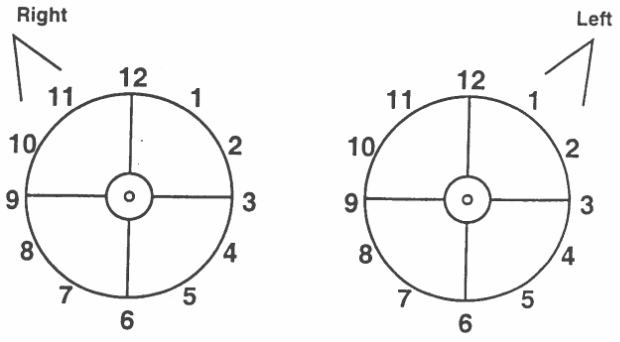
Reason for Current Examination

Follow-Up to Cancer	Right	Left
Implant rupture	Right	Left
Lump(s)	Right	Left
Pain	Right	Left
Nipple discharge (+ color)	Right	Left
Very high risk	Right	Left
Other	Right	Left

Remarks: _____

_____

PHYSICAL EXAMINATION (for office use



Remarks: _____

_____

_____

_____

Technologist: _____