Iris Cantor Center For Breast Imaging
MRI BREAST PATIENT QUESTIONNAIRE

Date: ____________________

Patient name: ____________________________  Birth date: ___/___/_____

Your primary physician: ___________________  Surgeon: ___________________

(If applicable)

Reason for exam:
___ Recently diagnosed breast cancer (R___ L___)  ___ Breast lump (R___ L___)
___ Personal history of breast cancer in the past (R___ L___)  ___ Implant problem (R___ L___)
___ High risk screening  ___ Pain in breast (R___ L___)
___ Large lymph nodes under arm  ___ Cancer elsewhere
___ Nipple discharge ( R___ L___ Color ________ )
___ Other: ________________________________

Previous mammogram/Ultrasound:
___ Yes ___ No  Date ___ / ___ / ______  Where: ________________________________

If not performed at UCLA did you bring the exam with you today?  Yes _____  No _____

Previous Breast MRI:
___ Yes ___ No  Date ___ / ___ / ______  Where: ________________________________

Have you ever had breast surgery or biopsy?  ____ Yes  ____ No

If yes  Which breast?  What were the results?  When?
(L, R or B)  (Benign, malignant, etc)  (Month, Day, Year)

Lumpectomy    ________    __________________________  ________________________
Mastectomy    ________    __________________________  ________________________
Breast Reduction  ________    __________________________  ________________________
Implant removed ________    __________________________  ________________________
Excisional Biopsy ________    __________________________  ________________________
Needle Biopsy    ________    __________________________  ________________________
Are you still menstruating?  Yes _____ No_____  If yes, first day of last menstrual period ___ / ___ / _______  Normal cycle length __________________ (days from one period to the next)

Have you taken birth control pills or hormone replacement therapy in the last six months?  Yes_____  No_____  If yes are you presently taking them?  Yes _____ No_____  If no, when did you discontinue use?  ___ / ___ /_______

Are you currently breast feeding?  Yes _____ No _____

Do you have a family history of breast cancer?  
Mother ___ Aunt ____ Sister ____ Grandmother ____ Other ______  Age(s) at diagnosis ______

Is there a personal or family history of ovarian cancer?  
Myself______Mother _____ Aunt______ Sister_____ Grandmother ____ Other______  
Age(s) at diagnosis ______

Have you had genetic counseling through a High Risk Program at UCLA?  Yes____  No ___

Your next appointment with your physician or surgeon is on:  ___ / ___ / _______

PLEASE SHOW LOCATIONS OF ANY BREAST LUMPS OR SURGERY SITES:

Patient Signature: _________________________________   Date: __________  Time: ________