Breast MRI Screening

Reason for MRI: _____

	Yes	No			
Do you feel a lump?	☐	☐	☐ Right	☐ Left	How long? _____
Does your doctor feel a lump?	☐	☐	☐ Right	☐ Left	How long? _____
Do you have breast pain?	☐	☐	☐ Right	☐ Left	How long? _____
Do you have nipple discharge?	☐	☐	☐ Right	☐ Left	How long? _____
Have you ever had breast cancer?	☐	☐	Treatment: _____		
Have you taken hormones? (Premarin, Birth Control, Estrogen, Provera Tamoxifen, herbal supplements, etc.)	☐	☐	Type/Date started/ended: _____		

Are you or could you be pregnant? ☐ ☐ Are you nursing? ☐ Yes ☐ No

Has your mother, sister, daughter, or other relative had breast cancer? ☐ Yes ☐ No
Person and age diagnosed: _____

Have you been tested for the breast cancer gene (BBCA gene test)? ☐ Yes ☐ No
If yes, were results: ☐ Positive ☐ Negative

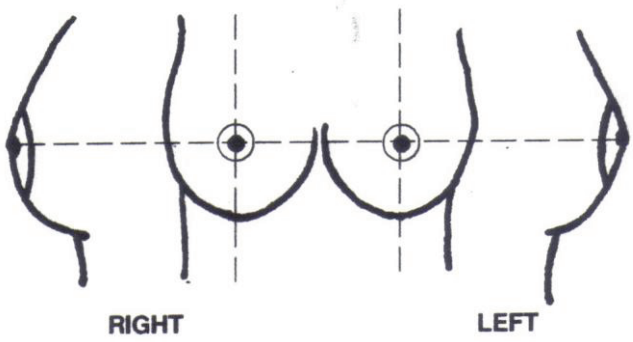
Are you still menstruating? ☐ Yes ☐ No If yes, first day of last menstrual period _____
Normal cycle length: _____ (days from one period to the next)

Last breast exam by Physician: _____ Date: _____

Last mammogram/ultra sound? Location: _____ Date: _____

---------- **Do Not Write Below This Line** ----------

Exam	Lt	Rt	Date	+ / -
Breast Reduction				
Breast Implants				
Cyst Aspiration				
(Stereo) (Ultra Sound) Guided Biopsy				
Lumpectomy				
Mastectomy				
Radiation Treatments				
Surgical Biopsy				



I, the undersigned, give Rowan Regional Medical Center permission to obtain my prior mammogram films, reports, and permission to obtain my confidential health record (follow-up breast surgery, pathology results and/or consultation notes).

Patient Signature: _____ Date: _____ Time: _____

Technologist _____ Date: _____ _____

If limited English proficient or hearing impaired, offer interpreter at no additional cost:

☐ Interpreter Accepted _____ ☐ Interpreter Refused
(Name/Number of Person/Services Chosen/Used)

NOVANT HEALTH

Breast MRI Screening

Name / MR # / Label