SOUTH COAST RADIOLOGY | DARLING DOWNS RADIOLOGY | MACKAY RADIOLOGY

MRI BREAST QUESTIONNAIRE

PATIENT_____

DATE _____

AGE

Your doctor has requested Magnetic Resonance Imaging scan of your breasts. The examination involves lying on your stomach on a padded table with your breasts placed within the imaging equipment. During the test you will be given an injection into the vein of MRI contrast (dye) called Gadolinium. The purpose of the MRI contrast is to help visualise the breast tissue. Usually you will feel no side effects from this. There is a very low incidence of minor allergic reaction from the injection. To aid in the interpretation of the images we will require some background information from you.

(Please tick appropriate answer)

1. What date are you seeing your doctor for the results of this MRI scan? _____/_____/_____

2. Have you had a mammogram previously? Yes ☐ No ☐
   If yes please indicate approximate date _____/_____/_____

3. Have you had a Breast Ultrasound previously? Yes ☐ No ☐
   If yes please indicate approximate date _____/_____/_____

4. Have you had a Breast MRI Previously? Yes ☐ No ☐
   If yes please indicate approximate date _____/_____/_____

5. Is there a history of breast cancer in your family? Yes ☐ No ☐
   If yes who? _____ At what age?_____

6. Have you ever been diagnosed with breast cancer? Yes ☐ No ☐
   If so, when? _____/_____/_____

7. Do you have a menstrual cycle? Yes ☐ No ☐
   If Yes what was the date of your last menstrual period? _____/_____/_____

8. Have you ever used hormone therapy? Yes currently ☐
   Yes but ceased in_____ Never ☐

9. Have you ever had trauma to your breast sufficient to cause bruising? Yes ☐ No ☐
   If Yes please indicate which side Right ☐ Left ☐ and date _____/_____/_____

10. Have you had a recent biopsy of your breast? Yes ☐ No ☐
    If Yes please indicate which side Right ☐ Left ☐ and date _____/_____/_____

11. Have you had surgery to your breast? Yes ☐ No ☐
    If Yes please indicate which side Right ☐ Left ☐ and date _____/_____/_____
    What was the surgery?_____

12. Do you have breast implants? Yes ☐ No ☐
Yes previously but since removed ☐

If Yes have you ever had them replaced? Yes ☐ No ☐

What material are your implants? Silicone ☐ Saline ☐ Unsure ☐

---

13. Have you ever had a breast expander? Yes ☐ No ☐

If Yes please indicate which side Right ☐ Left ☐ date _____/_____/_____

---

14. Have you had radiotherapy to your breast? Yes ☐ No ☐

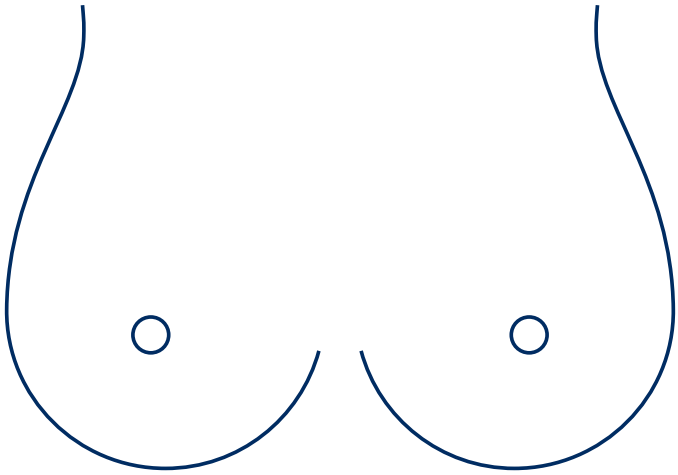
If Yes please indicate which side Right ☐ Left ☐ and date _____/_____/_____

---

15. Have you breast fed in the last few months? Yes ☐ No ☐

---

16. On the diagram below please draw the location of any known pathology, surgical scars or areas of concern (lumps, dimpling, pain etc.)



Patient signature _____ Date _____/_____/_____
