Portsmouth Regional Hospital **MRI Breast Symptom Form**

Name:_____

1) Do you currently have your menstrual cycle? ☐ No ☐ Yes

If yes, what was the first day of your last cycle?_____

If no, are you? ☐ Postmenopausal ☐ Hysterectomy ☐ Other_____

2) In your own words, what led your doctor to order your MRI today?_____

_____

3) Do you have a family history of breast cancer in a direct maternal relative such as your mother, sister, aunt or grandmother? ☐ No ☐ Yes If yes whom:_____

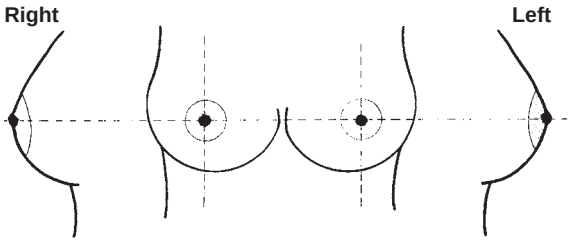
4) Have you had a breast cancer diagnosis? ☐ No ☐ Yes If yes ☐ Right ☐ Left ☐ Bilateral Date:_____

5) Have you had a breast biopsy, surgery or any other breast procedure?

☐ No ☐ Yes

If yes which breast: ☐ Right ☐ Left ☐ Bilateral

describe:_____



6) Have you had previous breast imaging done? ☐ No ☐ Yes If yes indicate below

☐ Mammogram: Date and Location:_____

☐ Ultrasound: Date and Location:_____

☐ MRI: Date and Location:_____

ALLERGIES:☐None☐Food☐Contrast Dye☐Tape☐Medications (include type of reaction with each allergy)

_____

_____

Patient Signature:_____ Date/Time:_____

Reviewer Signature:_____ Date/Time:_____

IV Site:	IV Gauge:	# of attempts:	Signature:
Contrast:	Radiologist:	Amount:	Signature:
Bun:	Creat: GFR	Date:	Signature:

Patient Information/Label