The IMAGING CENTER at COOKEVILLE REGIONAL
The Proven Choice

MRI BREAST IMAGING

NAME		**D.O.B.**	MR#

Have you recently had a mammogram? ☐ **Yes** ☐ **No**
How long ago? _____ **What facility?** _____
Have you recently had an ultrasound? ☐ **Yes** ☐ **No**
How long ago? _____ **What facility?** _____
Have you ever had cancer? ☐ **Yes** ☐ **No** **What type?** _____
Did you receive chemotherapy? ☐ **Yes** ☐ **No** **Radiation?** ☐ **Yes** ☐ **No**
Date of the first day of your last menstrual cycle? _____
PREFERABLE SCAN TIME IS 7 –12 DAYS AFTER FIRST DAY OF CYCLE
Are you post menopause? ☐ **Yes** ☐ **No**
Have you had a hysterectomy? ☐ **Yes** ☐ **No** **If yes, what age?** _____
Do you take hormone therapy ☐ **Yes** ☐ **No** **If yes, what type?** _____
Are you taking birth control? ☐ **Yes** ☐ **No**

FAMILY HISTORY OF CANCER		**If yes, what type?**
Mother	☐ **Yes** ☐ **No**	_____
Sister	☐ **Yes** ☐ **No**	_____
Daughter	☐ **Yes** ☐ **No**	_____
Grandmother	☐ **Yes** ☐ **No**	_____
Aunt	☐ **Yes** ☐ **No**	_____

Cousin _____
Other explain _____
If mother or sister had Breast cancer, was it before or after menopause? _____
Have you ever had surgery on your breasts? ☐ **Yes** ☐ **No**
If yes, what facility? _____

		LEFT	RIGHT	DATE	FACILITY
NEEDLE BIOPSY	☐ **Yes** ☐ **No**	_____	_____	_____	_____
NEEDLE ASPIRATION	☐ **Yes** ☐ **No**	_____	_____	_____	_____
SURGICAL BIOPSY	☐ **Yes** ☐ **No**	_____	_____	_____	_____
STEREOTACTIC BIOPSY	☐ **Yes** ☐ **No**	_____	_____	_____	_____
MASTECTOMY	☐ **Yes** ☐ **No**	_____	_____	_____	_____
LUMPECTOMY	☐ **Yes** ☐ **No**	_____	_____	_____	_____
REDUCTION	☐ **Yes** ☐ **No**	_____	_____	_____	_____
IMPLANTS	☐ **Yes** ☐ **No**	_____	_____	_____	_____

Please explain why your doctor has ordered this MRI and any problems you are currently experiencing.

_____
_____
_____

PATIENT ID STICKER

I M- 4 1