TEMPLETON IMAGING, Inc.

Selma Carlson Diagnostic Center

MRI Breast Health Questionnaire

Name:	Date of Birth:	MRN: Secondary MRN:
Date:	Referring Physician:	Account #:

Have you had a previous Mammogram/ Breast US / Breast MRI? _____

Where? _____ When? _____

Do you have any of the following? Please check all that apply.

Breast Implants	☐ Yes	☐ No	☐ Left	☐ Right	☐ Saline	☐ Silicone	
Breast Lumps	☐ Yes	☐ No	☐ Left	☐ Right			
Nipple Discharge	☐ Yes	☐ No	☐ Left	☐ Right	Discharge Color: _____		
Enlarged Underarm Glands	☐ Yes	☐ No	☐ Left	☐ Right			
Known Breast Cancer	☐ Yes	☐ No	☐ Left	☐ Right			

Other _____

Do you feel a **new** breast lump? ☐ Yes ☐ No If yes, Where? _____

For how long? _____ What size? _____

Have you had any previous breast surgeries? If yes, please circle side and date of surgery.

Benign Biopsy / Aspirations	☐ Yes	☐ No	Left	Date: _____	Right	Date: _____
Breast Cancer / Mastectomy	☐ Yes	☐ No	Left	Date: _____	Right	Date: _____
Lumpectomy	☐ Yes	☐ No	Left	Date: _____	Right	Date: _____

Personal Risk Factors

Number of Children: _____

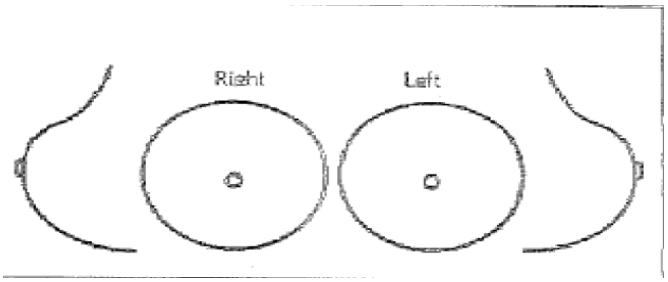
Age at first Childbirth: _____

Number of Children before age 30: _____

History of Breast, Uterine, Ovarian or

Colon Cancer: _____

Other: _____



Day of Cycle: _____ **Are you pregnant or a chance of you being pregnant?** ☐ Yes ☐ No

Are you taking birth control pills or hormone replacement therapy? ☐ Yes ☐ No

If yes, has the amount or the type changed in the last 6 months? If yes please explain: _____

_____

Do you have a family history of breast cancer? ☐ Yes ☐ No

If yes, please check relationship.

☐ Mother	☐ Daughter		
☐ Sister	☐ Grandmother,	☐ Paternal	☐ Maternal
☐ Other	☐ Aunt,	☐ Paternal	☐ Maternal

Patient Signature: _____ **Date:** _____

Tech Notes/Comments: _____