248-553-7275

Breast MRI History/Consent Form

Patient Name: ______________________ Age: ________ **Date:** ____________

Surgeon:: ______________________ Primary Physician: ______________________

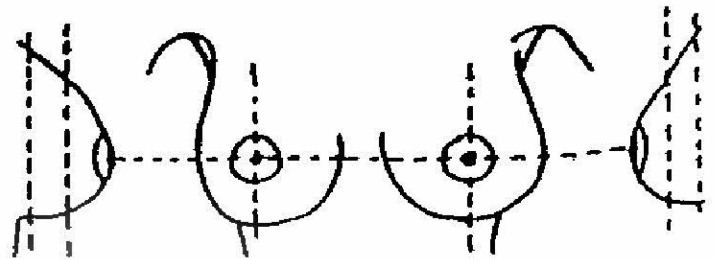
Social Security #:: ______________________ Start date last menstrual cycle: ______________________

	No	Lt	Rt
Enlarged Lymph glands	☐	☐	☐
Breast Lump?	☐	☐	☐
Nipple Discharge?	☐	☐	☐
Known breast cancer?	☐	☐	☐
Nipple discharge?	☐	☐	☐
Implants?	☐	☐	☐
Abnormal mammogram?	☐	☐	☐
Abnormal Ultrasound?	☐	☐	☐

	No	Yes
Are you nursing?	☐	☐

Please show location of any breast lumps or surgery sites

X=Lumps ----- = Surgery/Scar



Mastectomy/Lumpectomy? YES ☐ NO ☐
If yes, please describe including date of surgery.

Needle/Surgical Biopsy? YES ☐ NO ☐
If yes, please describe including date of biopsy.

History of cancer YES ☐ NO ☐
Other than breast? If yes, please describe

Previous Mammogram? YES ☐ NO ☐
If yes, please list dates/places

Previous Ultrasound? YES ☐ NO ☐
If yes, please list dates/places

Cyst aspiration? YES ☐ NO ☐
If yes, please describe including date of procedure.

Chemotherapy? YES ☐ NO ☐
If yes, please enter Start & Finsih dates .

Radiation Therapy? YES ☐ NO ☐
If yes, please enter Start & Finsih dates .

Family members with a history of breast cancer please list by relationship (Father's sister, etc)

Have you have taken oral hormones or used hormone cream within the last 6 months? If yes what type? How long off hormones ?

Signature: ______________________ Date: ______________________