RA0053

SOUTHAMPTON HOSPITAL

240 MEETING HOUSE LANE • SOUTHAMPTON, NY 11968

BREAST MRI PATIENT HISTORICAL INFORMATION FORM

PATIENT LABEL

MRUN # _____

Today's Date_____

Name: _____ _____
(LAST) (FIRST)

Date of Birth: _____ / _____ / _____ Telephone Number: _____

Physician: _____ Cell Phone Number: _____

Please answer the following questions:

1. Date of Last Menstrual Period: _____ / _____ / _____
2. Currently on hormones? ☐ Yes ☐ No Type: _____
3. Have you a Mother or Sister with history of breast cancer? ☐ No ☐ Yes ☐ Both
4. Have you been genetically tested positive for the BRCA gene? ☐ No ☐ Yes ☐ Both
5. Have you had a prior breast MRI? ☐ No ☐ Yes ☐ Both
6. Date of last Mammogram?_____ Where? _____
7. Have you ever had breast surgery or biopsy? ☐ No ☐ Yes Date? _____

   ☐Right ☐Left ☐Both When? _____
8. Have you undergone chemotherapy/irradiation? ☐ No ☐ Yes Date? _____

   ☐Right ☐Left ☐Both When? _____
9. Please describe the details of your breast surgery or biopsy below:

10. IMPLANT EVALUATION ONLY:

    a. Type: ☐ Silicone ☐ Saline ☐ Combined Saline/Silicone ☐ Other _____

    b. Year implants placed: Right side_____ Left Side _____ at Same Time: No☐Yes☐

    c. Any known suspected trauma?_____

    d. Do you have pain? ☐Right ☐Left