Cardinal Points IMAGING OF THE CAROLINAS

Breast MRI History

Patient: _____ Today's Date: ____/_____/_____

Date of Birth: _____/_____/_____Age: _____ Date of Last Menstrual Cycle: _____/_____/_____

Referring MD: _____ Primary Doctor, if different: _____

Why are you having a Breast MRI? _____

Date of Last Mammogram: _____ Did you bring your mammogram films with you? Yes No

Last mammogram performed at:

Facility: _____

Address: _____

Telephone: _____

Have you had a Breast MRI in the past? Yes No If yes, did you bring images with you today? Yes No

Facility: _____

Address: _____

Telephone: _____

Do you have a past history of Breast Cancer? Yes No If yes, date diagnosed: _____/_____/_____

Have you had previous breast biopsy or breast surgery? Right Left Both None

If yes, when: _____/_____/_____ Results: _____

Have the following family members had Breast Cancer?	Age at diagnosis	COMMENTS	Have the following family members had BRCA Gene?
Mother ☐ NO ☐ YES ☐ I don't know			Mother ☐ NO ☐ YES ☐ I don't know
Sister ☐ NO ☐ YES ☐ I don't know			Sister ☐ NO ☐ YES ☐ I don't know
Daughter ☐ NO ☐ YES ☐ I don't know			Daughter ☐ NO ☐ YES ☐ I don't know
Other ☐ NO ☐ YES ☐ I don't know			Other ☐ NO ☐ YES ☐ I don't know

Do you have breast implants? Yes No If yes, which type: Silicone Saline Both Unsure

Do you have breast tissue expanders? Yes No If yes, we cannot perform your procedure.

Have you had Chemotherapy? Yes No Date of Chemotherapy: _____/_____/_____

Have you had Radiation? Yes No Date of Radiation: _____/_____/_____

Are you currently on Hemodialysis? Yes No

Patient Signature: _____ Date: _____/_____/_____

Technologist Signature: _____ Date: _____/_____/_____

FOR OFFICE USE ONLY: I certify that I have 1) reviewed this form for completeness, 2) scanned this patient history into the RIS and 3) cleaned the MRI Unit before use on this patient.

_____ PRIORS SENT TO DYNACAD _____ PRIOR REPORTS UPLOADED INTO RIS IF PRIOR NOT AT CPIC