UCLA Health

MRN:
Patient Name:

(Patient Label)

Iris Cantor Center For Breast Imaging
MRI BREAST PATIENT QUESTIONNAIRE

Date: _____

Patient name: _____ Birth date: ___/_____/_____

Your primary physician: _____ Surgeon: _____
(If applicable)

Reason for exam:
___ Recently diagnosed breast cancer (R___ L___)
___ Personal history of breast cancer in the past (R___ L ___)
___ High risk screening
___ Large lymph nodes under arm
___ Cancer elsewhere
___ Nipple discharge (R ___ L ___ Color _____)
___ Other: _____

____ Breast lump (R ___ L ___)
____ Implant problem (R___ L___)
____ Pain in breast (R ___ L ___)

Previous mammogram/Ultrasound:
___ Yes ___ No Date ___ / ___ / _____ Where: _____

If not performed at UCLA did you bring the exam with you today? Yes ____ No _____

Previous Breast MRI:
___ Yes ___ No Date ___ / ___ / _____ Where: _____

Have you ever had breast surgery or biopsy? ____ Yes ____ No

If yes	Which breast? (L, R or B)	What were the results? (Benign, malignant, etc)	When? (Month, Day, Year)
Lumpectomy	_____	_____	_____
Mastectomy	_____	_____	_____
Breast Reduction	_____	_____	_____
Implant removed	_____	_____	_____
Excisional Biopsy	_____	_____	_____
Needle Biopsy	_____	_____	_____

UCLA Health System

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Are you still menstruating? Yes _____ No_____ If yes, first day of last menstrual period ___ / ____ /_____ Normal cycle length _____ (days from one period to the next)

Have you taken birth control pills or hormone replacement therapy in the last six months?
Yes _____ No _____
If yes are you presently taking them? Yes _____ No_____ If no, when did you discontinue use?
___ / ___ /_____

Are you currently breast feeding? Yes _____ No _____

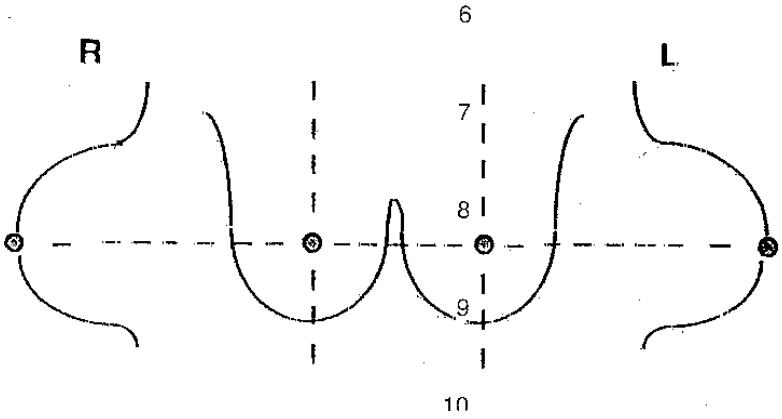
Do you have a family history of breast cancer?
Mother ___ Aunt ____ Sister ____ Grandmother ____ Other _____ Age(s) at diagnosis _____

Is there a personal or family history of ovarian cancer?
Myself_____Mother _____ Aunt_____ Sister_____ Grandmother _____ Other_____
Age(s) at diagnosis_

Have you had genetic counseling through a High Risk Program at UCLA? Yes___ No ___

Your next appointment with your physician or surgeon is on: ___ / ____ / _____

PLEASE SHOW LOCATIONS OF ANY BREAST LUMPS OR SURGERY SITES:



Patient Signature: _____ Date: _____ Time: _____