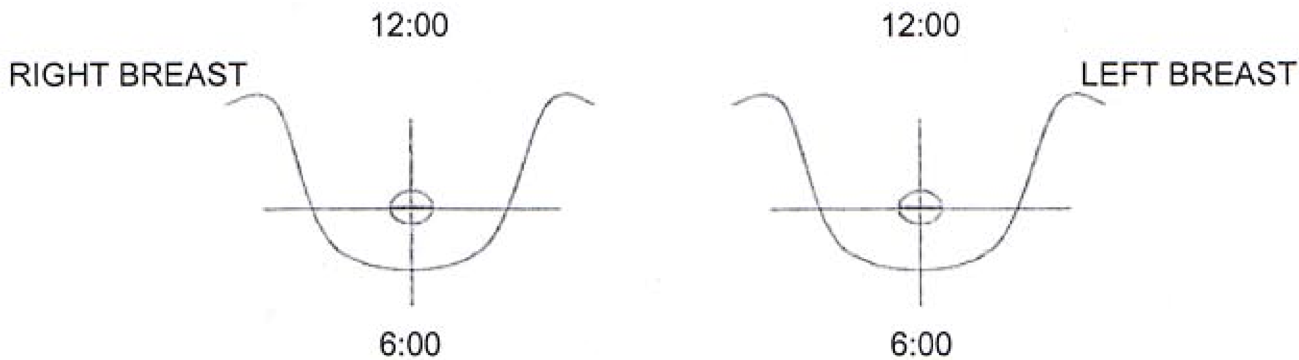
01862001

ValleyHealth
Winchester Medical Center

Winchester Medical Center Imaging Center
Patient History Form
MRI of Breast

1. Name of referring Physician ______________________________
2. Have you had a recent mammogram? Yes ____ No ____
   If yes, please list: Date ____________ Location ______________________
3. Have you had an ultrasound of your breast/s? Yes ____ No ____
   If yes, please list: Date ____________ Location ______________________
4. Do you have a history of breast cancer? Yes ____ No ____ Age at diagnosis ___
5. Do any family members have a history of breast cancer? Yes ____ No ____
   Age at diagnosis ____ Relationship to you ______________________
6. Could you be pregnant? Yes ____ No ____
7. When was the first day of your last menstrual period? ______________________
8. Do you use estrogen replacement hormones? Yes ____ No ____
   If yes, for how long have you taken estrogen? ______________________
9. Are you taking Tamoxifen (Soltamox) or Anastrozole (Arimidex)? Yes ____ No ____
10. Please circle or list what most closely represents your cultural origin:
    African-American   Asian/Pacific Islander
    Caucasian/White   Hispanic   Other: ______________
11. Do you have any breast symptoms, such as a lump, pain or discharge?
    Yes ____ No ____ if yes, please describe: ______________________
12. Have you had any previous breast surgery? Yes ____ No ____
    If yes, please list: Date ____________ Location ______________________
    Please mark the site of your past surgery on the diagram below:



Please indicate on the diagram above any of the following symptoms:

Redness ☐ Thickening ☐ Nipple retraction ☐
Previous biopsy ☐ Scar ☐ Mole☐
Skin ulceration ☐ Lump ☐ Skin discoloration ☐

Signature of patient: ______________________ Date: ______________________

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Patient Label: