

HIGH FIELD OPEN MRI PATIENT QUESTIONNAIRE
MRI BREASTS

Name _____ Date _____

Do you have a history of breast cancer? If yes, please detail.

Date of diagnosis _____

Do you have a history of any other cancer? If yes, please detail.

Date of diagnosis _____

Do you have a lump in either breast? If yes, please specify where

What complaints or symptoms led you to seek medical help?

How long have you had these symptoms? _____

Have you had or do you have now any of the following:

Please also state the date of the procedure or duration of the symptom.

	RIGHT	LEFT
Mastectomy	_____	_____
Lumpectomy	_____	_____
Biopsy results + or -	_____	_____
Discharge from nipples	_____	_____

Please note any other symptoms related to this exam and any results of previous studies.

