Breast Evaluation

Last Name ______________________________ First Name _________________________ Middle__________________

Date ____ Age ____

History: The reason for Breast MRI ____

Do you still menstruate? ☐ Yes ☐ No If so, what was the start date of your last period?__________________

Are you taking hormone replacement therapy? ☐ Yes ☐ No

Have you been diagnosed with Breast cancer? ☐ Yes ☐ No ☐ Right ☐ Left Date ___________________________

Do you have BRCA gene? ☐ Yes ☐ No

Do youhave family history of Breast cancer? ☐ Yes ☐ No Who? __________________________ Age ____________

Ovarian Cancer? ☐ Yes ☐ No Who? __________________________ Age _______________

When was your last mammogram? _______________________What was the result? ____________________________

Clinical Concerns: (CHECK ALL THAT APPLY)

Do you or your Doctor feel a lump? ☐ Yes ☐ No ☐ Right ☐ Left

Nipple discharge ☐ Right ☐ Left

Breast pain ☐ Right ☐ Left

Recent Breast injury ☐ Right ☐ Left

Breast skin changes _Right _Left

Abnormal mammogram/sonogram ☐ Right ☐ Left

Prior Breast Procedures: (CHECK ALL THAT APPLY)

☐ Fine Needle or Cyst Aspiration ☐ Right ☐ Left ☐ Benign ☐ Malignant Year ___________________________

☐ Needle or Core Biopsy ☐ Right ☐ Left ☐ Benign ☐ Malignant Year ____________________________________

☐ Surgical lumpectomy or biopsy/excision ☐ Right ☐ Left ☐ Benign ☐ Malignant Year _____________________

☐ Mastectomy If you had reconstruction, what type? ☐ Flap reconstruction ☐ Implant

☐ Breast Plastic Surgery If so, what type? ☐ Lift ☐ Reduction ☐ Implants (silicone or saline)

If you have implants, what type, how long? ____

Are your implants _______________________ under the muscle _______________________ over the muscle

Other Treatments: (CHECK ALL THAT APPLY)

☐ Radiation treatment to breast or chest ☐ Yes ☐ No Last Treatment Date: ________________________________

☐ Chemotherapy ☐ Yes ☐ No Last Treatment Date: ____