Name: _____

Daytime Phone Number: _____

Wayne MRI

together with wayne memorial hospital

Yes	No	
☐	☐	Are you having any problems with your breasts? If yes, please explain:
☐	☐	Have you had any previous breast surgeries? If Yes, which side? ☐ Left ☐ Right Was it ☐ Cyst ☐ Malignant ☐ Benign What year? _____
☐	☐	Do you have breast implants? If yes how long have you had them? _____ ☐Saline or ☐ Silicone
☐	☐	Have you been through menopause? If yes, at what age? _____
☐	☐	Have you had a hysterectomy? If yes, at what age? _____
☐	☐	Do you still have your ovaries?
☐	☐	Do you have a family history of breast cancer? If yes, what is their relationship to you? _____ What was their age when the breast cancer was detected? _____
☐	☐	Have you ever had previous mammograms? If yes, what was the date and facility where they were performed? _____ _____
☐	☐	Have you ever had previous Breast MRI's? If yes, what was the date and facility where they were performed? _____ _____
☐	☐	Do you take any hormone replacement therapy?
☐	☐	Are you on birth control?
☐	☐	Have you ever had Radiation Therapy? If yes, When? _____
_____		Number of pregnancies?
_____		Your age at the birth of your first child?
_____		If applicable, when did you start your last menstrual cycle?
_____		Your age when you started your menstrual cycle?

Mark any scars you have on the images. Technologist will place a marker on areas.

Right   Left

Right   Left