



MEDICAL PARK IMAGING
 AN IMAGING CENTER
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MR BREAST QUESTIONNAIRE

Name: _____ Birthdate: __/__/____

Primary physician: _____ Surgeon: _____

Reason for exam:

____ Implants ____ Enlarged lymph glands under arm
 ____ Breast lump (R____ L____) ____ Known breast cancer (R____ L____)
 ____ Nipple discharge (R____ L____) ____ Other: _____

Previous mammogram:

____ Yes ____ No Date __/__/____ Where? _____

Previous breast surgery?

Yes ____ No ____
 Right ____ Left ____ Benign ____ Malignant ____
 Date ____/____/____
 Mo year

Are you still menstruating? Yes ____ No ____ If yes, first day of last menstrual period __/__/____
 Normal cycle length _____ (days from one period to the next)

Are you breast feeding? Yes ____ No ____

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 __/__/____

Family history of breast cancer?

Mother _____ Aunt _____
 Sister _____ Grandmother _____

Next appointment with
 Your physician or surgeon?

____/____/____