Montclair Breast Center

37 N. FULLERTON AVE., MONTCLAIR, NJ 07042
MRI BREAST CENTER: (973) 746-5531

MRI: New Patient Questionnaire

Name: ______________________ Date: ______________________
Birthdate: ______________________ Date Last Menstrual Period: ______________________
Weight: __________ Any changes?__________ Height: ______________________
Ethnicity: Mother: __________ Father: __________ Ashkenazi Descent? ______________________
Have you had a previous Breast MRI? __________ If yes, where? ______________________
Allergic Reaction to Contrast: __________ If Yes, Details: ______________________
Age at First Period: ______ Date of Last Period:______ Age at First Live Birth: ______ Age at Menopause: ______ Bra Size: ______
Are you currently Pregnant? Is there a possibility you are Pregnant? ______________________
Recent Vaccine? ☐ No ☐ Yes: type, date & arm: __________ Genetic Testing (results)? ______________________
Date of last pap smear? __________ Date of last colonoscopy? __________ Results? ______________________
Do you have implants? ☐ No ☐ Yes If Yes, type: ______________________

CURRENT BREAST CONCERNS: Please describe and give location.

How many Breast Biopsies or Breast Surgeries have you had? __________ Any Atypia? ______________________
Aware of any new lumps today? ☐ No ☐ Yes, Rt ☐ Yes, Lt How long? ______________________
Recent breast pain or soreness? ☐ No ☐ Yes, Rt ☐ Yes, Lt How long? ______________________
Discharge from nipple? Color? ☐ No ☐ Yes, Rt ☐ Yes, Lt How long? ______________________
Any recent breast trauma? ☐ No ☐ Yes, Rt ☐ Yes, Lt How long? ______________________
Skin changes/thickening? ☐ No ☐ Yes, Rt ☐ Yes, Lt Describe: ______________________
Other problems/concerns? ☐ No ☐ Yes, Rt ☐ Yes, Lt Explain: ______________________
History of diabetes? ☐ No ☐ Yes
Do you have any kidney issues? ☐ No ☐ Yes If Yes, explain: ______________________
Do you currently smoke? ☐ No ☐ Yes If Yes, how many years? ______ When did you quit? __________
Do you take hormones/estrogen? ☐ No ☐ Yes If Yes, when did you start and stop? ______________________
Please list any medications you are taking: ______________________
Do you have personal history of cancer? ☐ No ☐ Yes If Yes, what type, when and age: ______________________
Family history of breast cancer? ☐ No ☐ Yes If Yes, who, type and age of diagnosis: ______________________
Breast: ______________________
Ovarian: ______________________
Other: ______________________
Number (living and deceased) of Maternal Aunts: ______ Paternal Aunts: ______ Daughters: ______ Sisters: ______

SAFETY QUESTIONS:

Do you have one of the following? Please circle below:

Pacemaker	Removable Dental	Implants/Prosthesis	Pins/Body Piercing
Artificial Heart Valve	Work Hearing Aid	Aneurysm Clip	Medication Patches
Pumps (Insulin, etc.)		Wig/Hairclip/Bobby	Cosmetic Tattooing

Have you done any welding, grinding, or cutting of metal? ☐ Yes ☐ No
Is there any metal in your eyes? ☐ Yes ☐ No

PATIENT HAS COMPLETED AND REVIEWED QUESTIONNAIRE:

Patient Signature: ______________________ Date: ______________________
Best Contact Phone # For Results: ______________________
Support Person Asked Safety Questions (Signature): ______________________
Technologist Initials: ______________________