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

MRI Questionnaire

Name: _____ Date: _____
Birthdate: _____ Age: _____
Weight: _____ Height: _____
How many pregnancies? _____ How many live births? _____
Age at first full-term pregnancy? _____
When was your last mammogram? _____ Where: _____
Have you had a previous Breast MRI? _____ If yes, where? _____
Sedation? _____ Pharmacy: _____
Allergic Reaction to Contrast: _____ If Yes, Details: _____
Present complaints: _____
Starting date of last menstrual cycle: _____

PATIENT HISTORY:

Could you be pregnant? ☐ Yes ☐ No
Are you breastfeeding? ☐ Yes ☐ No
Do you take hormones? ☐ Yes ☐ No
Do you have implants? ☐ Yes ☐ No If Yes, type: _____
Family history of breast cancer? ☐ Yes ☐ No If Yes, who: _____
Do you have any kidney issues? ☐ Yes ☐ No If Yes, explain: _____
Do you currently smoke? ☐ Yes ☐ No ☐ Former Smoker
Do you have personal history of breast cancer? ☐ Yes ☐ No If Yes, when: _____
Have you had chemotherapy or radiation? ☐ Yes ☐ No If Yes, explain: _____
Have you had breast surgery? _____ When: _____ Results: _____
Are you currently taking Tamoxifen/Arimidex? ☐ Yes ☐ No ☐ In the past, if so/how long: _____
Are you currently taking a hormone medication, patch, or cream? ☐ Yes ☐ No If yes, did you stop at least 10 days ago: __

SAFETY QUESTIONS:

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

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

Have you done any welding, grinding, or cutting of metal?
Is there any metal in your eyes?

PATIENT HAS COMPLETED AND REVIEWED QUESTIONNAIRE:

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