



# Montclair Breast Center

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

## MRI Questionnaire

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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? \_\_\_\_\_  
 Allergic Reaction to Contrast: \_\_\_\_\_ If Yes, Details: \_\_\_\_\_  
 Present complaints: \_\_\_\_\_  
 Starting date of last menstrual cycle: \_\_\_\_\_  
 Recent Vaccine?  No  Yes: type, date & arm: \_\_\_\_\_ Age at Menopause: \_\_\_\_\_

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

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:

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