Windsong Radiology Group
Where patients come first.

BREAST MRI PATIENT SCREEN

Name: _____ DOB: _____ Height: _____ Weight: _____

Date: _____ Referring Doctor: _____ Radiology #: _____

Please read carefully and answer YES or NO to the following items:

Have you ever had an MRI before? Yes No
Are you claustrophobic? Yes No
Do you have allergies (including latex)? Yes No
If yes, what? _____

DO YOU HAVE:

- Kidney Disease Yes No
- Diabetes Yes No
- Insulin pump (for diabetes) Yes No
- Transdermal patches Yes No
- Cardiac pacemaker or wires from a pacemaker Yes No
- Vascular clips: brain*, aortic, or carotid clips Yes No
- Prosthetic heart valve* (other heart surgery) Yes No
- Metal fragments (shrapnel, gunshot wound, welding or sheet metal injury), especially metal fragments near eye* Yes No
- Breast expanders* Yes No
- Neurostimulators (TENS Unit) Yes No
- Shunt (ventricular or spinal) Yes No
- Stents (need card) Yes No
- Joint replacement, artificial limb Yes No
- Metal plates, pins, screws, spine rod, or other metal bone devices Yes No
- Wire sutures Yes No
- Hickman or Broviac catheter Yes No
- Eye Prosthesis Yes No
- Intrauterine Device (IUD) Yes No
- Middle ear prosthesis or cochlear implant Yes No
- Hearing Aid Yes No
- Dentures or braces Yes No

These particular items may not allow us to proceed with your examination

Prior surgeries: _____
_____

CONTRAST CONSENT

I understand contrast material may be injected. The indications for and risks of the procedure known as an MRI were discussed with me. The risks were noted to include, but are not limited to, various types of allergic reactions to the intravenous contrast. Most of these reactions are minor, although they can be severe at times. On rare occasions, inflammation or infection at the site can occur and other more remote risks or consequences may also arise.

I have been advised that if further explanation is desired, I may ask additional questions to the staff to include any supervising radiologists and my referring physician.

_____ _____
Signature of patient or legal guardian Date

_____ _____
Staff witness to signature Date

FEMALE PATIENTS:
☐ I AM PREGNANT ☐ I AM NOT PREGNANT / LMP _____
I understand and hereby release all radiologists, respective staff and the facility thereof of any and all responsibility for any adverse reaction to myself and/or damage to my unborn fetus in the event I may be pregnant.

SIGNATURE _____

PLEASE CONTINUE ON REVERSE SIDE

BREAST SPECIFIC HISTORY

1. Have you ever had breast cancer? Yes No Atypia or Lobular (LCIS) Yes No

   Please list any other Cancer: _____

   Breast Biopsy? Yes No If yes, # biopsies _____ ☐ Surgical or ☐ Core Biopsy?

   Circle Results: RT breast: Benign Malignant

   LT breast: Benign Malignant

   Treatments: ☐ Lump removed ☐ Chemotherapy
   ☐ Lymph node removed ☐ Radiation
   ☐ Entire breast removed ☐ Both breasts removed

   Breast Implants? Yes No If yes, Type: _____ Year placed _____
   ☐ Right ☐ Left

2. **Diagnostic exams:** (Please circle)

Mammogram	Yes No	Date _____	Where _____
Breast MRI	Yes No	Date _____	Where _____
Ultrasound Breast	Yes No	Date _____	Where _____
PET/CT	Yes No	Date _____	Where _____

3. First Day of LMP _____ Menopause? Yes No
   Use of Estrogen Replacement Hormones? Yes No
   Use of Tamoxifen / Arimidex / Aromasin? Yes No
   Family History of breast cancer? Yes No
   ☐ Mother ☐ Sister Age when diagnosed _____

4. **Complaints:** (Please check all that apply)
   RT Breast: ☐ Pain ☐ Lump ☐ Nipple Discharge ☐ Other_____
   LT Breast: ☐ Pain ☐ Lump ☐ Nipple Discharge ☐ Other_____

Patient Signature _____ Date _____

TECHNOLOGIST NOTES ONLY _____ (Initials) Vit. E markers _____