Ocala Health
Advanced Imaging Centers

BREAST MRI HISTORY

Patients previous Mammograms, Breast Ultrasounds, and Breast MRI images must be here to complete the study.

Mammogram Date _____ Location _____

Breast Ultrasound Date _____ Location _____

Breast MRI Date _____ Location _____

MEDICAL HISTORY

Any family history of Breast Cancer? _____No ____ Yes

_____Mother/Age_____ | _____Sister/Age_____ | _____Daughter/_____ | _____Grandmother/Age_____

Last menstrual period date:_____ Start of menstruation: _____Age | Year_____

Are you postmenopausal? ____No ____Yes _____Age | Year_____

Are you pregnant? ____No ____Yes (Number of pregnancies) ____

Are you taking hormone replacement? ____No ____Yes (Name)_____
If YES – how many years? _____

Any allergies to medications? ____No ____Yes (List)_____

Diagnosed with cancer other than breast? ____No ____Yes (Name)_____

BREAST SURGICAL HISTORY

Do you have breast implants? ____No ____Yes _____Age | Year_____

Have you had breast reduction? ____No ____Yes _____Age | Year_____

Have you had a breast biopsy? ____No ____Yes (Which breast)_____

____ Surgical _____Fine Needle _____Core Findings?_____

Have you had Breast Cancer? ____No ____Yes _____

Lumpectomy? ____No ____Yes (Side)_____

Mastectomy? ____No ____Yes (Side)_____

What treatments have you had? ____Chemotherapy ____Radiation Therapy ____Tamoxifen

BREAST COMPLAINTS

____Right ____Left Lump, mass, thickening _____

____Right ____Left Nipple discharge _____

____Right ____Left Focal pain _____

____Right ____Left Skin or nipple changes_____

____Right ____Left Other _____

I affirm that the above information is correct. I understand that it may take a few days for the radiologist to review and interpret the thousands of images generated and processed for this study and to review my history and prior studies.

Patient Name:_____ Date:_____

Patient Signature: _____

Technologist reviewing history:_____ Date:_____