



QUAKERBRIDGE RADIOLOGY ASSOCIATES

BREAST MRI QUESTIONNAIRE

TEL: 609-890-0033 FAX: 609-890-0440

PATIENT NAME: _____

DOB: _____ AGE: _____ WEIGHT: _____ HEIGHT: _____

SEX: FEMALE / MALE FIRST DAY OF LAST MENSTRUAL PERIOD _____
(Appointment **must** be scheduled the 10th to the 14th day after the above date)

BREAST EXAM: R / L

REFERRING PHYSICIAN: _____

REFERRING PHYSICIAN PHONE: _____

PLEASE CIRCLE YES OR NO FOR THE QUESTIONS BELOW:

ARE YOU TAKING HORMONES? YES NO

IS THE PATIENT CLAUSTROPHOBIC? YES NO

CAN THE PATIENT LIE ON THEIR BELLY FOR 40 MINUTES? YES NO

DOES THE PATIENT HAVE ANY PHYSICAL DISABILITIES? YES NO

DOES THE PATIENT HAVE PRIOR IMAGING STUDIES? YES NO

***If yes, films and reports of prior studies must accompany the patient on exam date.
(This includes mammogram, breast ultrasound and breast MRI studies.)***

IMPORTANT INFORMATION

1. If you had a biopsy please schedule your **Breast MRI** two weeks post op.
2. It is important to hydrate. Drink plenty of water the night before and the morning of the exam.

APPOINTMENT DATE: _____ APPOINTMENT TIME: _____