

RAI PATIENT HISTORY MRI BREAST:

Technologist/Tech Aide: _____

Today's Date: _____ **Patient Scanned for Metal:** Yes No **RAI Tech:** _____

Name: _____ **Age:** _____ **Weight:** _____ **Referring Physician:** _____

1. Reason for exam: palpable mass known breast cancer abnormal ultrasound nipple discharge
 abnormal mammogram family history breast cancer abnormal biopsy dense breast
 personal history of breast cancer other: _____ Length of symptoms: _____
 breast implants: saline or silicone

2. List family members who have a history of cancer: _____

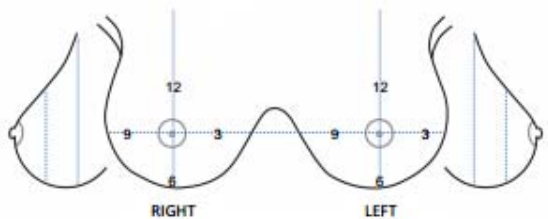
3. Have you had prior breast surgery: Y – N If yes, what type?
- | | | | |
|--|--------------------------------|-------------------------------|-------------|
| <input type="checkbox"/> Benign biopsy | <input type="checkbox"/> right | <input type="checkbox"/> left | date: _____ |
| <input type="checkbox"/> Malignant biopsy | <input type="checkbox"/> right | <input type="checkbox"/> left | date: _____ |
| <input type="checkbox"/> Lumpectomy biopsy | <input type="checkbox"/> right | <input type="checkbox"/> left | date: _____ |
| <input type="checkbox"/> Cyst Aspiration | <input type="checkbox"/> right | <input type="checkbox"/> left | date: _____ |
| <input type="checkbox"/> Mastectomy | <input type="checkbox"/> right | <input type="checkbox"/> left | date: _____ |

4. Do you have a history of cancer? Circle: Y - N Type? _____

5. Any radiation treatment? Y - N start/end? _____ Any chemotherapy? Y - N start/end? _____

6. Symptoms & History: Pain or Tenderness right left One side larger than another right left

- | | | | | | |
|------------------|-------|---------------|-------|-------|-------|
| Mass or Lump | L / R | Axillary Mass | L / R | Pain | L / R |
| Nipple Inversion | L / R | Skin Dimpling | L / R | Moles | L / R |
| Nipple Discharge | L / R | Scars | L / R | Other | L / R |



7. Describe any existing medical conditions (high blood pressure, diabetes): _____

8. List ALL current medications: _____

9. Do you have any known allergies? _____

10. **If Injury:** Date of Injury: _____ Please specify: _____

11. Prior Diagnostic Imaging: Breast Studies (MAMMO/US/MRI):

Study/Date/Facility: _____

12. Have you experienced any problem related to a previous MR examination or MR procedure? Yes - No

If yes, please describe: _____

13. Have you had an injury to the eye involving a metallic object or fragment (i.e.; metallic slivers, shavings, foreign body, etc.)?

Yes - No If yes, please describe: _____

14. Have you ever been injured by a metallic object or foreign body (i.e.; BB, bullet, shrapnel, etc.)? Yes - No

If yes, please describe: _____

15. Has your physician prescribed any sedation or medication specifically for this examination? Yes - No

If yes, please indicate type and amount _____

16. FOR FEMALE PATIENTS:

1. Date of last menstrual period: _____ Post-menopausal? Yes - No

2. Are you pregnant or experiencing a late menstrual period? _____ Yes - No

3. Currently Breastfeeding? Or within past three months? _____ Yes - No

Comments: _____

_____ (see back of form)

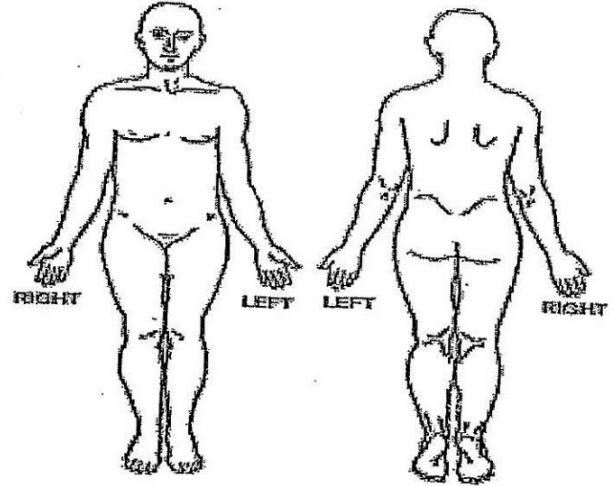


WARNING: Certain implants, devices or objects may be hazardous to you and/or may interfere with the MR procedure (i.e. MRI, MR angiography, functional MRI, MR spectroscopy). **Do not enter** the MR system room or MR environment if you have any question or concern regarding an implant, device, or object. Consult the MRI Technologist or Radiologist BEFORE entering the MR system room.
The MR system magnet is ALWAYS on.

Please indicate if you have any of the following:

- Yes No Aneurysm clip(s)
- Yes No Cardiac pacemaker
- Yes No Implanted cardioverter defibrillator (ICD)
- Yes No Electronic implant or device
- Yes No Magnetically-activated implant or device
- Yes No Neurostimulation system
- Yes No Spinal cord stimulator
- Yes No Internal electrodes or wires
- Yes No Bone growth/bone fusion stimulator
- Yes No Cochlear, otologic, or other ear implant
- Yes No Any type of prosthesis (eye, penile, etc.)
- Yes No Heart valve prosthesis
- Yes No Eyelid spring or wire
- Yes No Artificial or prosthetic limb
- Yes No Metallic stent, filter, or coil
- Yes No Shunt (spinal or intraventricular)
- Yes No Vascular access port and/or catheter
- Yes No Radiation seeds or implants
- Yes No Swan-Ganz or thermodilutin catheter
- Yes No Medication patch (Nicotine, Nitroglycerine, birth control)
- Yes No Any metallic fragment or foreign body (bullet, pellets, shrapnel)
- Yes No Any wire mesh implant
- Yes No Tissue expander (e.g., breast)
- Yes No Surgical staples, clips, or metallic sutures
- Yes No Joint replacement (hip, knee, etc.)
- Yes No Bone/joint pin, screw, nail, wire, plate, etc.
- Yes No IUD, diaphragm, or pessary
- Yes No Dentures or partial plates
- Yes No Tattoo or permanent makeup
- Yes No Body piercing jewelry
- Yes No Hearing aid (*Remove before entering the MR system room*)
- Yes No Other implant _____
- Yes No Breathing problem or motion disorder
- Yes No Claustrophobia

Please mark on the figure(s) below the location of any implant or metal inside of OR on your body.



!	IMPORTANT INSTRUCTIONS
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Before entering the MR environment or MR system room you must remove all metallic objects including hearing aids, dentures, partial plates, keys, beeper, cell phone, eyeglasses, hair pins, barrettes, jewelry, body piercing jewelry, watch, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools, clothing with metal fasteners, & clothing with metallic threads.

Please consult the MRI Technologist or Radiologist if you have any question or concern BEFORE you enter the MR system room.

NOTE: You may be advised or required to wear earplugs or other hearing protection during the MR procedure to prevent possible problems or hazards related to acoustic noise. MRI is generally a safe procedure. Qualified medical personnel will be present throughout the entire procedure. The FDA has determined that MRI presents no great risk.

I attest that all information provided is correct to the best of my knowledge and that I will not bring any type of metallic objects into the MRI room including but not limited to hearing aids, weapons, watches, electronics, etc. I read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and regarding the MR procedure that I am about to undergo. I understand I cannot hold Radiology Affiliates liable for injury or loss of personal property due to my own negligence.

Signature of Person Completing Form: _____

Date: _____

Form Completed By: Patient Relative Other _____
Print name

Relationship to Patient

Form Information Verified by: _____
Print name

Signature