

**AUSTIN RADIOLOGICAL ASSOCIATION  
BREAST MRI WORKSHEET**

**Patient Information** (to be filled out by patient):

\_\_\_\_\_ **Patient's Last Name**      \_\_\_\_\_ **First Name**      \_\_\_\_\_ **Previous Last Name**      \_\_\_\_\_ **Date of Birth**

Have you ever had a mammogram, breast ultrasound or breast MRI? \_\_\_\_\_

If yes, where and when was it performed? \_\_\_\_\_

What was the date of the first day of your last menstrual period? \_\_\_\_\_

Are you currently using any hormones? Yes / No If yes what type and for how long? \_\_\_\_\_

Have you ever had breast surgery or other breast procedures? \_\_\_\_\_ If yes, please circle type and list dates:

Type of Procedure	Which Breast?	Dates Procedures Performed?	
Biopsy	Left or Right	_____	What type? Needle or Surgical
Augmentation (Implants)	Left or Right	_____	What type? Saline or Silicone
Reduction	Left or Right	_____	
Aspirations	Left or Right	_____	
Mastectomy	Left or Right	_____	
Lumpectomy (due to Cancer)	Left or Right	_____	
Radiation Therapy	Left or Right	_____	

**Personal History**

Have you ever been diagnosed with breast cancer? \_\_\_\_\_ If yes, when, by what type of biopsy and which breast? \_\_\_\_\_

Has a blood-related family member ever had breast cancer? \_\_\_\_\_

If yes, who was it and at what age was the diagnosis? \_\_\_\_\_

**Current History**

Any possibility you may be pregnant? Yes / No

Are you currently breastfeeding? Yes / No

Have you tested positive for BRCA 1 or BRCA 2? Yes / No or NA (have not been tested)

What is the reason for this examination? Please check the most appropriate blanks below:

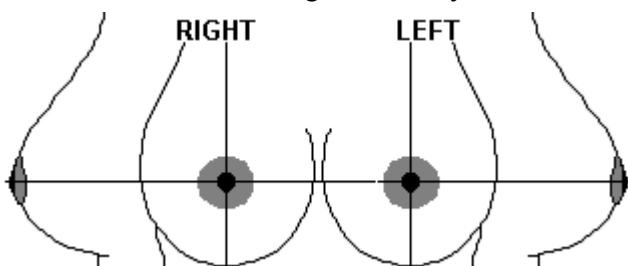
\_\_\_ **Screening**, \_\_\_ I am not aware of any breast problems, \_\_\_ I have a strong family history of breast cancer,  
\_\_\_ I am BRCA 1 and/or BRCA 2 positive (circle as appropriate), \_\_\_ other

\_\_\_ **Not routine**, I have a \_\_\_ breast lump, \_\_\_ skin thickening or dimpling, \_\_\_ nipple changes, \_\_\_ nipple discharge  
\_\_\_ follow-up to recent mammo or breast sono, \_\_\_ new diagnosis of breast cancer, \_\_\_ other.

Please describe in more detail any areas checked above: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

For Technologist Use Only:



Technologist please document areas such as-  
lump, scar, site of biopsy, etc.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_