

# Thumb MRI

## BREAST MRI HISTORY

Name \_\_\_\_\_ Date \_\_\_\_\_ Age \_\_\_\_\_  
Your primary physician \_\_\_\_\_ Surgeon \_\_\_\_\_  
Next appointment with physician/surgeon \_\_\_\_\_  
Contrast Dose \_\_\_\_\_ Start date of last menstrual period \_\_\_\_\_

Reason for today's exam:

Enlarged lymph glands under arm (R \_\_\_\_\_ L \_\_\_\_\_) Breast lump (R \_\_\_\_\_ L \_\_\_\_\_)  
Nipple discharge (R \_\_\_\_\_ L \_\_\_\_\_) Known breast cancer (R \_\_\_\_\_ L \_\_\_\_\_) Implants (R \_\_\_\_\_ L \_\_\_\_\_)  
Abnormal Mammogram \_\_\_\_\_ Abnormal Ultrasound \_\_\_\_\_ Other \_\_\_\_\_

Age of family member diagnosed with breast cancer:

Grandmother \_\_\_\_\_ Mother \_\_\_\_\_ Sister \_\_\_\_\_ Aunts \_\_\_\_\_ Daughters \_\_\_\_\_ Other \_\_\_\_\_

### RIGHT Breast

Date of: Mastectomy/Lumpectomy \_\_\_\_\_

Date of: Surgical Biopsy \_\_\_\_\_  
Results \_\_\_\_\_

Date of: Needle Biopsy \_\_\_\_\_  
Results \_\_\_\_\_

Date of: Cyst aspiration \_\_\_\_\_  
Results \_\_\_\_\_

Size of Cancer \_\_\_\_\_

Chemotherapy Dates: Start \_\_\_\_\_ Finish \_\_\_\_\_

Radiation Dates: Start \_\_\_\_\_ Finish \_\_\_\_\_

Date of Implant/s \_\_\_\_\_ Date of Reduction/s \_\_\_\_\_

Type of Implant/s \_\_\_\_\_

Any cancer history - self (other than breast) Yes \_\_\_\_\_ No \_\_\_\_\_ Type \_\_\_\_\_

Previous Mammogram:

Yes \_\_\_\_\_ No \_\_\_\_\_ Date \_\_\_\_\_

Where? \_\_\_\_\_

Previous Ultrasound:

Yes \_\_\_\_\_ No \_\_\_\_\_ Date \_\_\_\_\_

Where? \_\_\_\_\_

Have you taken any oral hormones/estrogen or hormones/estrogen cream within the last 6 months?

No \_\_\_\_\_ Yes \_\_\_\_\_ Type \_\_\_\_\_

How long have you been off hormones \_\_\_\_\_

Are you nursing? Yes \_\_\_\_\_ No \_\_\_\_\_

Have you felt any lumps? Yes \_\_\_\_\_ No \_\_\_\_\_

Has your doctor felt any lumps? Yes \_\_\_\_\_ No \_\_\_\_\_

Please show location of any breast lumps or surgery sites...

**X = Lumps** --- = **Surgery/Scar**

