



ROSETTA RADIOLOGY
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BREAST MRI QUESTIONNAIRE

Name _____ Account # _____

Age _____ Date of Birth _____ Weight _____

Referring Doctor: _____ Date of last Mammogram: _____

Are you pregnant? _____ Using the start of your menstrual cycle as Day 1, what day
are you in today? _____

Have you had any surgery? If yes, please explain _____

Do you have any history of breast cancer in your family? If yes, please indicate their age at diagnosis.

Mother: _____ Sister: _____ Aunt: _____ Grandmother _____
Other: _____

Have you had any of the following treatment?

Lumpectomy: R or L Chemotherapy: R or L Radiation: R or L

Hormone Therapy Yes or No Birth Control Yes or No

Breast Implants: Saline or Silicone Mastectomy: R or L

Have you been diagnosed with any of the following? If yes, please indicate when and which breast.

Atypical Ductal Hyperplasia (ADH): R or L Invasive Breast Cancer R or L

Atypical Lobular Hyperplasia: R or L Multiple Papillomas: R or L

Lobular Carcinoma In-Situ (LCIS) R or L Positive for BRCA Mutations R or L

Non-Invasive Ductal Carcinoma In-Situ (DCIS) R or L

Any other cancer? If yes, please explain: _____

Reason for today's Breast MRI: _____

Do you have any breast problems today? If yes, please indicate which breast: _____

Breast lump R or L Nipple Retraction R or L Breast Thickening R or L

Nipple Discharge R or L Pain/Tenderness R or L Implant Integrity R or L