NORTHERN ARIZONA RADIOLOGY

Breast MRI Patient Questionnaire

Date of exam:_____ Patient name: _____

DOB: _____ Age:_____

History of breast conditions:

1. Do you have a palpable lump in your breast that you can feel? ○ Yes ○ No ○ Left ○ Right ○ Both
   If yes, for how long? _____

2. Are you experiencing breast pain? ○ Yes ○ No ○ Left ○ Right ○ Both

3. Do you have a grandmother, mother or sister with a history of breast or ovarian cancer? ○ Yes ○ No
   If yes, who? _____

4. Have you had breast surgery? ○ Yes ○ No ○ Left ○ Right ○ Both Dates:_____

5. Do you have surgical clips placed in your breast? ○ Yes ○ No ○ Left ○ Right ○ Both

6. Do you have breast implants? ○ Yes ○ No ○ Left ○ Right ○ Both
   If yes: (circle) Silicone Saline Combination

7. Do you have a history of breast cancer? ○ Yes ○ No ○ Left ○ Right ○ Both
   What kind, if known? _____

If you have a history of breast cancer: Radiation ○ Yes ○ No Dates: _____
Chemotherapy ○ Yes ○ No Dates: _____

8. Are you or have you taken Hormone Replacement Therapy (HRT) ○ Yes ○ No
   If yes, dates you took HRT: _____
   If no, date last period began:_____

9. Are you taking birth control? ○ Yes ○ No

10. Menstrual Cycle: Menopausal? ○ Yes ○ No If no, date last period began:_____

Other breast exam performed:

LIST ANY THAT APPLY	FACILITY WHERE PERFORMED *(hospital, clinic, physician's office)*	DATE OF PROCEDURE
○ Mammogram		
○ Breast MRI		
○ Ultrasound		
○ Other		

Please do not write below, Technologist notes:

Technologist's signature: _____ Date:_____

Revised (January 2014)

REQUEST FOR PRIOR MAMMOGRAM FILMS / CD, BREAST ULTRASOUND FILMS / CD, AND REPORTS

NORTHERN ARIZONA RADIOLOGY, P.C.

77 West Forest Avenue, Suite 101
Flagstaff, AZ 86001
Phone: 928 773-2515 Opt 4 Fax: 928 773-2521

This authorization for disclosure of medical information is being requested to comply with the terms of the Confidentiality of Medical Information Act of 1981, Civil Code section 56 et seq. and the Health Insurance Portability and Accountability Act 1996 (HIPAA).

It is very important that we obtain any prior mammograms, breast ultrasounds and reports from other facilities where you had your last exam done. Previous films are used for comparison to provide the most accurate reading. Once we obtain your prior films they are compared with your current films for reading by our board certified radiologist.

The maximum waiting period for prior films is 4 weeks. If, at the end of this time the films are not received we will process your current mammogram without comparison and we may ask you to return for additional mammogram views.

PLEASE PRINT THE NAME & ADDRESS OF YOUR MOST RECENT MAMMOGRAM BELOW:

_____

(NAME AND ADDRESS OF FACILITY)

_____

(PHONE AND FAX NUMBER)

*PLEASE PRINT YOUR NAME*_____

*ANY PREVIOUS NAME USED*_____

*HOW LONG AGO WAS YOUR LAST MAMMOGRAM*_____

*YOUR DATE OF BIRTH*_____ *SOCIAL SECURITY #*_____

By signing below, I authorize the release of medical records to Northern Arizona Radiology, P.C. and agree to hold harmless your facility for any action related to the release of records. Northern Arizona Radiology, P.C. agrees to return original x-rays films as soon as possible. I am aware that your facility may be unable to reproduce damaged or misplaced films. Records may not be re-released to another party without my authorization unless permitted by law.

*SIGNATURE*_____ *DATE*_____

If signed by other than the patient, indicate relationship:_____

*WITNESS:*_____ *DATE*_____