



Montclair Breast Center MRI
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MRI QUESTIONNAIRE

PT ID# _____
 Name: _____ Date: _____
 D.O.B. _____ Age: _____ Weight: _____ Height: _____
 When was your last mammogram? _____ Where: _____
 Present complaints _____
 Starting date of last menstrual cycle **(Please fill out)** _____

PATIENT HISTORY:

Could you be pregnant? Yes No
 Are you breast feeding? Yes No
 Do you take hormones? Yes No
 Family history of breast cancer? Yes No Who? _____
 Do you have personal history of breast cancer? Yes No When? _____
 Have you had breast surgery? When _____ Results _____
 Have you had chemotherapy or radiation? _____
 Do you have implants? Yes No Type _____
 Do you have kidney problems? Yes No Explain _____

SAFETY QUESTIONS:

Do you have one of the following? Please circle below

Pacemaker	Implants/Prosthesis
Artificial Heart Valve	Aneurysm Clip
Pumps (Insulin, etc.)	Wig/Hairclip/Bobby Pins/Body Piercing
Removable Dental Work	Medication Patches
Hearing Aid	Cosmetic Tattooing

Have you done any welding, grinding, or cutting of metal? _____
 Is there any metal in your eyes? _____

PATIENT HAS COMPLETED AND REVIEWED QUESTIONNAIRE:

PATIENT SIGNATURE: _____ **DATE** _____
TECHNOLOGIST INITIALS: _____
NOTES: _____