BREAST IMAGING PATIENT INFORMATION
PALM HARBOR MRI
32615 US HWY 19 N STE #4
PALM HARBOR, FL 34684-3176
Phone: 727-787-6900
Fax: 727-787-1892

Date:

Patient:

MRN:

Sex:

Age:

Weight: _____

Referring Physician:

PATIENT HISTORY:

☐ Yes ☐ No Have you had a mammogram before? If so, when and where? _____

☐ Yes ☐ No Have you had any other breast imaging? If so, when and where? _____

Are you having any of the following problems? (Check all that apply)

☐	None (Check one or both)	☐ Left ☐ Right
☐	Lump - how long? _____	☐ Left ☐ Right
☐	Nipple discharge - describe below (color/how long)	☐ Left ☐ Right
☐	Pain - how long? _____	☐ Left ☐ Right
☐	Breast implant problem - describe below	☐ Left ☐ Right
☐	Nipple inversion - (circle one) ALWAYS or NEW	☐ Left ☐ Right
☐	Other - describe below	☐ Left ☐ Right

Please describe problems stated above:

_____

_____

Do you have breast implants? ☐ Yes ☐ No If yes, which side? ☐ Left ☐ Right

Have you ever been diagnosed with breast cancer? ☐ Yes ☐ No If yes, which side? ☐ Left ☐ Right

Have you ever had breast surgery (biopsy, reduction / lift)? ☐ Yes If so, when ? _____ ☐ No

If yes, which side? ☐ Left ☐ Right

Please describe?

_____

Are you pregnant now? ☐ Yes ☐ No

Are you taking hormone medication? ☐ Yes ☐ No

If yes, what type ? _____ How long? _____

Do you have a family history of breast cancer?

☐ Mother: Age _____ Diagnosis _____

☐ Sister: Age _____ Diagnosis _____

☐ Daughter: Age _____ Diagnosis _____

It is important that I continue monthly breast self-exams according to the American Cancer Society guidelines. I also realize that a visit to my physician for a physical examination of my breasts is an important part of my routine breast screening check-up.

Patient Signature: _____ Date: _____