



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)

- | | | |
|---|-------------------------------|--------------------------------|
| <input type="checkbox"/> None (Check one or both) | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Lump - how long? _____ | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Nipple discharge - describe below (color/how long) | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Pain - how long? _____ | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Breast implant problem - describe below | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Nipple inversion - (circle one) ALWAYS or NEW | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Other - describe below | <input type="checkbox"/> Left | <input type="checkbox"/> 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:** _____