RADNET MANAGEMENT, INC.

Facility: ______________________________

MRI HISTORY FORM

FORM.POL.002
Effective Date: August 1, 2010

MR BREAST IMPLANT HISTORY

Name: ______________________________ Age:_______ Date:_____________

Reason for this examination: ______________________________

Have you had a Mammogram/Sonogram before? ☐Yes ☐ No When: _________ Where:______________

Have you ever had a Breast MRI before? . . . . . . ☐Yes ☐ No When: _________ Where:______________

PHYSICAL IMPLANT		**Right**	**Left**	**Date of Surgery**
Silicone?	☐Yes ☐ No	______	______	____________________
Saline?	☐Yes ☐ No	______	______	____________________
Single Lumen?	☐Yes ☐ No	______	______	____________________
Double Lumen?	☐Yes ☐ No	______	______	____________________
Retro-pectoral (behind chest muscle)? . .	☐Yes ☐ No	______	______	____________________
Retro-glandular (over chest muscle)? . . .	☐Yes ☐ No	______	______	____________________

Type of Implant: ______________________________

Additional Information:______________________________

BREAST SURGICAL / IMPLANT HISTORY		**Right**	**Left**	**Date**
Did you have breast implants before these?	☐Yes ☐ No	____	____	__________

If so, why were they removed?______________________________

Did you have steroid solution placed with original implants?	☐Yes ☐ No	____	____	__________
Did you have silicone or paraffin injections in your breasts?	☐Yes ☐ No	____	____	__________
Did you have steroid injections in your breasts?	☐Yes ☐ No	____	____	__________
Are you planning to have the breasts implants removed? . .	☐Yes ☐ No	____	____	__________
Have you ever had “closed capsulotomies” where the doctor presses firmly on your breast to release contractions or fibrous bands? If so, list approximate date(s)	☐Yes ☐ No	____	____	__________

GENERAL HISTORY

Are you pre-menopausal? . . . ☐Yes ☐ No. . .1st day of your last menstrual period: _____________

Pre-menopausal patients should be scheduled between days 7-10 from the start of last period.

Day of cycle today:_______________

Are you post-menopausal?. . . ☐Yes ☐ No . . . . . If yes, since when?________________________

Are you on hormone replacement therapy?. . ☐Yes ☐ No . . . If so, list type:____________________

If you quit taking hormone replacement therapy, how long ago did you quit?___________________

List any symptoms related to your implants: ______________________________

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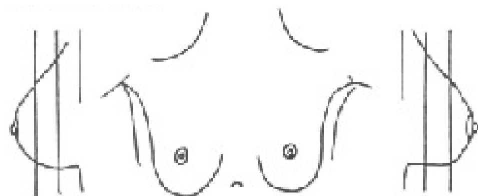
OFFICE USE ONLY



Clinical indications/Notes:______________________________

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____

Technologist’s Name:______________________________

To the best of my knowledge, all of the above is true and correct.

Patient Signature: ______________________________ Date: _______/_______/_______