Patient Name: _____

DOB: _____

Breast Surgical History

Why are you having a breast MRI today?

_____

_____

Have you had breast surgery?_____ If yes, the type of surgery/right, left or bilateral _____

_____

Have you had chemotherapy? _____If yes, please state the dates:_____

Have you had radiation to the chest area? _____If yes, please state the dates:_____

Are you scheduled to have breast surgery?_____ If yes, when it is scheduled. _____

This section for MRI Staff only:

Indicate date(month/year) of each incident, right, left or both breasts and whether benign(B) or malignant(M) if applicable

	R	L	B	B/M		R	L	B
Cyst Aspiration					Mastectomy			
Needle Biopsy					Radiation/ end of treatment			
Lumpectomy OR Excisional Biopsy					Reduction Implants (circle) Saline Silicone			