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MRI QUESTIONNAIRE

MR #: _____

Name: _____

Age: _____ Date of Birth: _____ Weight: _____

Are you pregnant? Yes _____ No _____ Last Menstrual Period: _____

Using the first day of your menstrual cycle as Day 1, what day are you in today? _____

Referring MD _____

Do you have renal disease? Yes No Are you diabetic? Yes No

Do you have liver disease? Yes No

If Yes, to either: BUN/Creatinine _____

Have you had any surgery? Yes _____ No _____

Please explain: _____

Do you have a history of breast cancer in your family? (If yes, please indicate the age of diagnosis)

Mother _____ Sister _____ Aunt _____ Grandmother _____ Other _____

Have you been diagnosed with the following: (if yes, please indicate when and which breast)

Atypical Ductal Hyperplasia (ADH) R or L

Invasive breast cancer R or L

Atypical Lobular Hyperplasia (ALH) R or L

Multiple papillomas R or L

Lobular Carcinoma In-Situ R or L

Positive for BRCA mutations R or L

Non-Invasive Ductal Carcinoma In-Situ R or L

Any other cancer (Please explain): _____

Have you had any of the following treatments? (If yes, please indicate when and where)

Lumpectomy R or L Mastectomy R or L

Chemotherapy R or L Radiation R or L

Hormone Therapy/Birth Control Y or N

Reason for breast MRI today? _____

When was your last mammogram? _____

Do you have any breast problems today? (If yes, please indicate which breast) _____

Breast lump R or L Nipple retraction R or L Breast thickening R or L

Cancer elsewhere _____ Pain/tenderness R or L Nipple discharge R or L
 Implant integrity R or L Abnormal mammo/sono R or L
 Other: _____

Please indicate if you have the following:

Aneurysm clip	Yes _____	No _____
Cardiac Pacemaker	Yes _____	No _____
Implanted cardioverter defibrillator (ICD)	Yes _____	No _____
Electronic implant or device	Yes _____	No _____
Magnetically activated implant or device	Yes _____	No _____
Neurostimulation system	Yes _____	No _____
Spinal cord stimulator	Yes _____	No _____
Internal electrodes or wires	Yes _____	No _____
Bone growth/bone fusion stimulator	Yes _____	No _____
Cochlear otologic or other ear implants	Yes _____	No _____
Insulin or other infusion pump	Yes _____	No _____
Implanted drug infusion device	Yes _____	No _____
Any type of prosthesis	Yes _____	No _____
Heart valve prosthesis	Yes _____	No _____
Eyelid spring or wire	Yes _____	No _____
Artificial or prosthetic limb	Yes _____	No _____
Metallic stent, filter or coil	Yes _____	No _____
Shunt (spinal or intraventricular)	Yes _____	No _____
Vascular access port and/or catheter	Yes _____	No _____
Radiation seeds or implants	Yes _____	No _____
Swan-Ganz or thermodilution catheter	Yes _____	No _____
Medication patch (Nicotine, Nitroglycerin)	Yes _____	No _____
Any metallic fragment or foreign body	Yes _____	No _____
Wire mesh implant	Yes _____	No _____
Tissue expander (e.g. breast)	Yes _____	No _____
Surgical staples, clips or metallic sutures	Yes _____	No _____
Joint replacement (hip, knee, etc.)	Yes _____	No _____
Bone/joint pin, screw, nail, wire, plate, etc.	Yes _____	No _____
IUD, diaphragm or pessary	Yes _____	No _____
Dentures or partial plates	Yes _____	No _____
Tattoo or permanent makeup	Yes _____	No _____
Body piercing jewelry	Yes _____	No _____
Hearing aid	Yes _____	No _____
Other implant _____		

Please make sure to remove all metal objects. This includes watches, jewelry, keys, hair pins, coins, and cell phones. Please note credit cards and bank cards may be erased in the MRI scan room.

Please consult the MRI technologist or Doctor if you have any questions or concerns BEFORE you enter the MRI system room.

I attest that the above information is correct to the best of my knowledge. I have read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and regarding the MRI procedure that I am about to undergo.

Signature of person completing form: _____

Date: _____ Form completed by: _____
Form reviewed by: _____
MRI technologist _____ Physician _____ Other _____