NYMI
NEW YORK MEDICAL IMAGING ASSOCIATES
Drs. Maklansky, Kurzban, Cohen, Zimmer, Hyman, Berson, Maklansky

PATIENT'S NAME: _____ DOB: _____DATE: _____

MRI BREAST IMAGING QUESTIONNAIRE

1. Have you had a mammogram performed within the last 5 years? □**Yes** □ **No**
If so, when:_____ where:_____

2. Have you ever had breast surgery? □**Yes** □ **No** if so, Type:
□**BIOPSY** □**ASPIRATION** □**MASTECTOMY** □**LUMPECTOMY** □**RADIOTHERAPY** □**IMPLANTS** □**REDUCTION**
Which Breast(s)? □**Right** □ **Left** □**Both** When?:_____
Results: □**Benign** :_____ □**Malignant**:_____

5. Are you experiencing any problems with your breasts now? □**Yes**□ **No** if so, please indicate:
□**Lump**----------□**Right** □**Left** □**Both**
□**Discharge** ----------□**Right** □**Left** □**Both**
□**Pain/Tenderness**--------□**Right** □**Left** □**Both**
□**Other**:_____

4. Do you have a family history of **BREAST** cancer? □**Yes** □ **No**
If so, (check all that apply**):**□**Mother** □**Father** □ **Sister** □**Grandmother** □ **Aunt** □ **Other**
If so, what age ?: _____

6. When was the last time your breasts were physically examined by your physician? :_____

NOTE: IF YOU BROUGHT OLD FILMS WITH YOU, PLEASE NOTIFY THE RECEPTIONIST

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1. Do you have any allergies? (including shellfish/seafood) YES NO

If yes, please write down what you are allergic to: _____

2. Have you received intravenous contrast previously? YES NO
3. Have you had an adverse reaction to intravenous contrast? YES NO

YES	NO		YES	NO	
		4. Kidney failure?			**12.** Recent heart attack?
		5. On dialysis?			**13.** A diagnosis of **Myeloma**?
		6. Single kidney?			**14.** Diabetes?
		7. Asthma?			**15.** Taking Glucophage/Glucovance/Metformin?
		8. Sickle cell disease?			**16. Pulmonary** hypertension?
		9. Heart disease?			**17.** Respiratory failure?
		10. Arrhythmia?			**18.** Pregnant?
		11. Angina pectoris?			**19.** Breast feeding?

PLEASE READ AND SIGN BELOW:

I, the undersigned patient, hereby authorize the doctors to perform radiological examination with administration of IV contrast and such additional procedures as are considered therapeutic on the basis of the findings during the course of the said procedure. I hereby certify that I have read and fully understand the above.

Name: _____ Date: _____

Signature: _____Weight:: _____ Employee Initial:_____