MNAP Medical Solutions

9908 East Roosevelt Boulevard, Philadelphia, PA 19115
Phone 215-464-3300 | Fax 215-464-5403 | www.mnap.com

Breast MRI Evaluation

Name | **Date of Birth**

Email

Describe your symptoms

How long have you had those symptoms?

What treatments have you tried?

☐ Physical Therapy ☐ Surgery ☐ Injections ☐ Exercise ☐ Chiropractic ☐ Massage ☐ None

MRI Brain (Check off any of the following symptoms you are experiencing)

☐ Headaches	☐ Dizziness	☐ History of stroke. Describe _____	
☐ Seizure	☐ Vertigo	☐ History of cancer. Describe _____	
☐ Syncope	☐ Slurred speech	☐ History of trauma. Describe _____	
☐ Off balance	☐ Aphasia (language)	☐ Body numbness or weekness	○ L ○ R
☐ Memory loss	☐ Blurred/Doubled vision	☐ Facial numbness	○ L ○ R
☐ Confusion	☐ Altered or loss of smell	☐ Hearing loss	○ L ○ R
☐ Ataxia (coordination)	☐ Difficulty swallowing	☐ Tinnitus	○ L ○ R

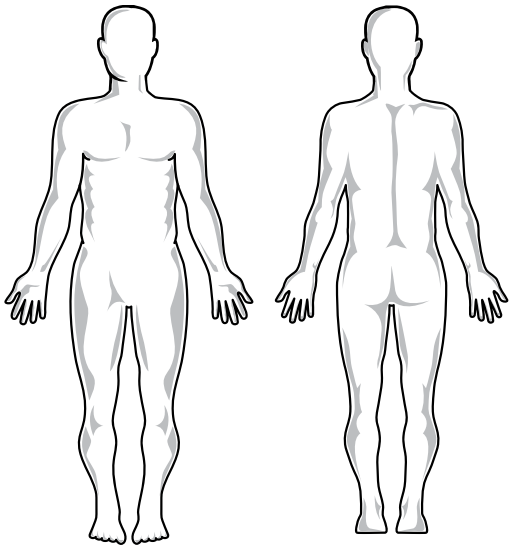
MRI Spine / Extremity
(Check off any of the following symptoms you are experiencing)

☐ Neck pain	☐ Shoulder pain	○ L ○ R
☐ Upper back pain	☐ Arm pain	○ L ○ R
☐ Mid back pain	☐ Hand/finger pain	○ L ○ R
☐ Lower back pain	☐ Hip pain	○ L ○ R
☐ Right flank pain	☐ Leg pain	○ L ○ R
☐ Left flank pain	☐ Foot/toe pain	○ L ○ R
☐ Chest pain	☐ Arm numbness	○ L ○ R
☐ Abdominal pain	☐ Finger numbness	○ L ○ R
☐ Pelvic/groin pain	☐ Leg numbness	○ L ○ R

☐ Trauma _____

☐ Surgery _____

Please shade in areas which hurt



Front Back

Continued on Next Page →

Please tell us whether or not you have a history of any of the following medical conditions:

			Comments
Cardiac Pacemaker	☐ Yes	☐ No	
Brain Aneurysm Clips	☐ Yes	☐ No	
Eye Implants	☐ Yes	☐ No	
Ear Implants	☐ Yes	☐ No	
Hearing Aid	☐ Yes	☐ No	
Vascular/Surgical clips	☐ Yes	☐ No	
Shunts/Stents	☐ Yes	☐ No	
Pumps	☐ Yes	☐ No	
Prosthesis	☐ Yes	☐ No	
Wire Sutures	☐ Yes	☐ No	
Any Type of Stimulator (ie,Tens Unit)	☐ Yes	☐ No	
Any Type of Foreign Body, Bullet, Iron	☐ Yes	☐ No	
An IUD or Pessary	☐ Yes	☐ No	
Dentures, or a Dental Bridge or Implant	☐ Yes	☐ No	
Tattoo Eyeliner	☐ Yes	☐ No	

				Comments
Is there any chance there could be metal in your eye? (Do you work with metal welding, cutting or grinding?)	☐ Yes	☐ No		
Do you have a history of cancer?	☐ Yes	☐ No		
Are you pregnant or a nursing mother?	☐ Yes	☐ No		
The date of your last menstrual period _____				
Any previous surgery?	☐ Yes	☐ No		
If yes, what kind and when _____				
Have you had any other testing for this problem?	☐ MRI	☐ CT	☐ X-ray	
Is this a work related injury?	☐ Yes	☐ No		
If yes, date of injury _____				
Is this related to a motor vehicle accident?	☐ Yes	☐ No		
If yes, date of accident _____				
Is there litigation pending?	☐ Yes	☐ No		

Continued on Next Page →

Has anyone had breast cancer? ☐ Yes ☐ No

If yes, who ☐ Mother ☐ Sister ☐ Grandmother ☐ Daughter ☐ Maternal Aunt

Has anyone had ovarian carcinoma? ☐ Yes ☐ No

If yes, who ☐ Mother ☐ Sister ☐ Grandmother ☐ Daughter ☐ Maternal Aunt

Medication history

Birth Control ☐ Yes ☐ No

Are you currently using? ☐ Yes ☐ No How long?

Estrogen ☐ Yes ☐ No

Are you currently using? ☐ Yes ☐ No How long?

Enter your menstrual history

Age when period started		Age at natural menopause	
Age at left ovary removal		Number of live births	
Age at first full term pregnancy		Age at hysterectomy	
Age at right ovary removal			

Previous procedures? ☐ Yes ☐ No	**Date**
○ L ○ R Cyst aspiration	
○ L ○ R Ultrasound core biopsy	
○ L ○ R Excisiorial biopsy (noncancerous)	
○ L ○ R Stereotactic biopsy	
○ L ○ R Lumpectomy for cancer	
○ L ○ R Mastectomy	
○ L ○ R Radiation therapy	
○ L ○ R Breast reduction	
○ L ○ R Implant removed	

Do you have implants? ☐ Yes ☐ No	**Date**
○ L ○ R I don't know the specific type	
○ L ○ R Silicone gel implant	
○ L ○ R Saline implant Date	
○ L ○ R Combination implant	
○ L ○ R Prepectoral implant	
○ L ○ R Retropectoral implant	

Have you ever received chemotherapy for any type of cancer?

☐ Yes ☐ No

Patient Signature	**Date**

Technologist Signature	**Date**

For office use only below this line