



San Luis Diagnostic Center
 1100 Monterey Street, Suite 210
 San Luis Obispo, California 93401

(805) 542-9700 • Fax (805) 542-0584
 www.SLDCinfo.com

NAME: _____ <small>Last Name, First Name Middle Initial</small>
WEIGHT: _____

CONSENT FOR BREAST MRI

Please complete this form to the best of your ability. If you do not know the answer, please leave it blank. If our doctor deems it necessary to get this information we will contact you.

The following may interfere with an MRI exam, and some could be hazardous to your health.

Do you have (a/an/any)

Heart Pacemaker/Defibrillator?	Yes	No	Stent?	Yes	No
Aneurysm clips from brain surgery?	Yes	No	Cochlear Implant(s)?	Yes	No
Kidney Disease or Kidney problems?	Yes	No	Artificial Joint(s)?	Yes	No
Surgical Clips?	Yes	No	Harrington Rods?	Yes	No
Artificial heart valve(s)?	Yes	No	Wire Sutures?	Yes	No
Insulin Pump?	Yes	No	Dentures?	Yes	No
Hearing Aid(s)?	Yes	No	Are you pregnant or nursing?	Yes	No
Possibility of metal fragments in your eyes?	Yes	No	Mechanical device worn externally or implanted internally?	Yes	No
Cosmetic piercings or implants? (Other than dental implants)	Yes	No			

To complete your MRI exam, we may need to administer a special MR contrast agent. The contrast agent is given through a needle placed into your vein. This contrast is considered very safe. Infrequently, a patient will have a mild reaction to the contrast. The radiologist and the technologists at San Luis Diagnostic Center are trained to treat such reactions. To date, only a very few serious reactions to the agent have been reported in the United States.

Signed: _____ Date: _____

Relationship to patient: Self Parent or guardian of minor patient Guardian or conservator of patient

Please remove the following items before having your MRI examination.
 Secure them and all your valuables in your dressing room locker.

- | | | | |
|------------------------|---------------------|----------|-------------|
| Hearing aids | Wallet/Credit cards | Wig | Dentures |
| Jewelry (except rings) | Keys | Hairpins | Safety pins |

(Continued on Back)



BREAST IMAGING HISTORY

(Complete this form to the best of your ability.)

Name: _____ Date of Birth: _____
Last First Middle Initial

Exam Date: _____ Date of last breast exam in doctor's office: _____

If menopausal, age menopause began: _____

Have you had a previous mammogram? No Yes If yes, where & when: _____

Have you had a previous Breast MRI? No Yes If yes, where & when: _____

Have you taken hormones or birth control pills within 3 months? No Yes If yes, date started: _____

Reason for this exam: Routine check-up Other

If other:	Right	Left
<input type="checkbox"/> Lump	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Pain	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Discharge	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Injury to breast (within six weeks)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other	<input type="checkbox"/>	<input type="checkbox"/>
Please explain:		

Previous breast procedure(s)	Right	Left	Year
<input type="checkbox"/> Implants	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Breast Biopsy	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Cyst Aspiration	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Breast Reduction	<input type="checkbox"/>	<input type="checkbox"/>	

I have been diagnosed with Breast Cancer	Right	Left	Year
<input type="checkbox"/> Mastectomy	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Lumpectomy	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Radiation Therapy?			<input type="checkbox"/> No <input type="checkbox"/> Yes

1. What was your age at the time of your first menstrual period?	Don't Know	14 or older	12 to 13	7 to 11		
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
2. What is your current age?		35 to 45	46 or older			
		<input type="checkbox"/>	<input type="checkbox"/>			
3. What was your age at the time of your first live birth of a child?	Don't Know	Younger than 20	20 - 24	25 - 29	30 or Older	No Births
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. How many of your first-degree relatives (mother, sisters, daughters) have had breast cancer?	Don't Know	0				1 More than 1
	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/> <input type="checkbox"/>
5. Have you ever had a breast biopsy? If yes, see questions 5a & 5b.	Don't Know	No			Yes	
	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	
5a. How many breast biopsies have you had?		1			More than 1	
		<input type="checkbox"/>			<input type="checkbox"/>	
5b. Have you had at least one biopsy with atypical hyperplasia?		No	Don't know			Yes
		<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>
6. Have you ever personally tested positive for the BRCA1 or 2 gene? (The "Breast Cancer Gene")	Don't Know	No				Yes
	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>

FOR OFFICE USE ONLY:

Total	Office Use Only					
	0	0	1	2	3	8

