TOWER IMAGING
MEDICAL · GROUP
Imaging by Specialists

23929 McBean Parkway, Suite 109
Valencia, California 91355
TEL: (661) 753-5400
FAX: (661) 753-5401

BREAST MRI

Patient Name: _____ Date of Birth: _____

Referring MD: _____Phone #: _____

Clinical History

Do any of the following concern you? ❑ Yes ❑ No

❍ Lump ❍ Nipple Retraction ❍ Discharge ❍ Breast Pain ❍ Dimpling

If Yes, ❍ Right ❍ Left ❍ Both

Have you ever had breast surgery? ❑ Yes ❑ No

If Yes, did you have a

❑ Lumpectomy ❍ Right ❍ Left Year _____

❑ Mastectomy ❍ Right ❍ Left Year _____

❑ Reduction ❍ Right ❍ Left Year _____

❑ Benign Biopsy ❍ Right ❍ Left Year _____

❑ Implants ❍ Right ❍ Left Year _____ Type: _____

Imaging History

Prior Mammogram: ❑ Yes ❑ No

If yes, Where? _____ Date: _____

Prior Ultrasound: ❑ Yes ❑ No

If yes, Where? _____ Date: _____

Prior Breast MRI: ❑ Yes ❑ No

If yes, Where? _____ Date: _____

Is this a six month follow-up for previous imaging findings? ❑ Yes ❑ No

Medical History

Have you breast fed within the last 4-6 months? ❑ Yes ❑ No

Do you have any other medical conditions? ❑ Yes ❑ No If yes (explain) _____

_____

When was the first day of your last menstrual period? _____