

Patient History Questionnaire (MRI)

Patient Account Number: _____

Patient Name: _____

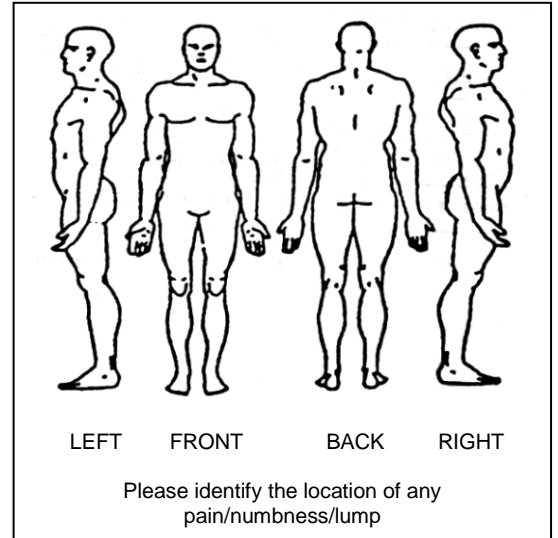
Date: _____

Reason for Procedure:

Please check any of the following symptoms that you are experiencing:

- Chest pain
- Abdominal pain
- Pelvic Pain
- Back pain
- Shoulder pain - (Right/ Left)
- Leg pain - (Right/ Left)
- Arm pain - (Right/ Left)
- Headaches
- Blackouts
- Dizziness
- Neck pain
- Nausea
- Blurred vision
- Memory loss
- Unexpected weight loss
- Numbness - (Right side/ Left side)
- Weakness - (Right side/ Left side)
- Other: _____
- Hearing loss
- Ringing in ears
- Seizures

How and when did these symptoms occur (e.g., injury, just started, etc.)?



Medical History:

1. Do you have or have you had any of the following?

- Cancer
- Seizures
- Diabetes
- Asthma, bronchitis or emphysema
- Heart disease
- Sickle cell anemia
- Congenital heart defect
- Kidney/renal disease
- Tumor, lump or mass
- Glaucoma
- Other illness/disease: _____
- Multiple myeloma
- Bleeding tendency
- Stroke
- Hypertension
- Heart arrhythmia

2. Have you had any tests (MRI, CT, X-Ray, etc.) performed for the symptoms you are currently experiencing? Yes No

If yes, please list the date, type and who performed the test: _____

3. Have you had any surgeries or therapies (e.g., radiation therapy, chemotherapy, etc.)? Yes No

If yes, please list the date and type of surgery or therapy: _____

4. Are you currently taking any medications? Yes No

If yes, please list all medications you are currently taking: _____

5. Do you have any allergies (e.g., medications, latex, food, etc). Yes No

If yes, please list all allergies: _____

I hereby certify that the above information is true and correct to the best of my knowledge.

Patient or Legal Representative Signature

Print Name and Authority (if legal representative)

Date

Technologist Notes: _____
