

POLARIS OPEN MRI

Patient History Questionnaire (MRI)

Patient Account Number: _____

Patient Name: _____

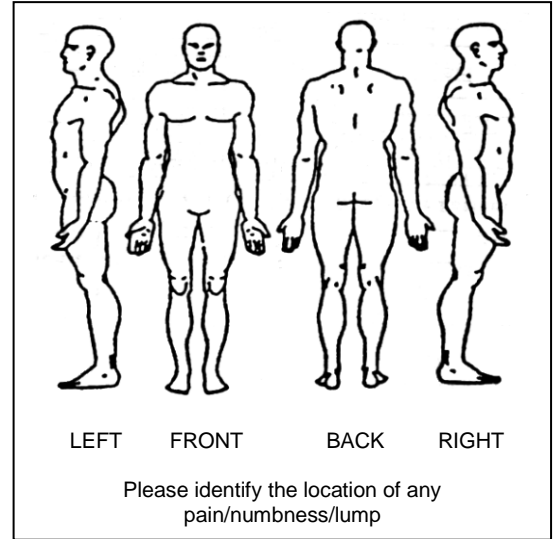
Date: _____

Reason for Procedure:

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

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

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?

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

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: _____

