MRI HISTORY FORM

Patient Name: _____ MR#: _____ Date: _____

DOB: _____ Age: _____ Height: _____ Weight: _____ ☐ Male ☐ Female

ALL FEMALES: Date if last menstrual period: _____ Are you, or could you be pregnant? ☐ YES ☐ NO

Are you breast feeding? ☐ YES ☐ NO Are you postmenopausal? ☐ YES ☐ NO

►CHECK ALL SYMPTOMS RELATED TO THE TYPE OF MRI SCAN YOU ARE HAVING

SHOULDER / ARM / ELBOW / HAND
HIP / LEG / ANKLE / FOOT

Body Part: _____

☐ Right ☐ Left

☐ Limited Range of Motion

☐ Weakness

☐ Popping

☐ Grinding

☐ Swelling

☐ Lump or Mass

Location of Pain:

☐ Front ☐ Back ☐ Inside ☐ Outside

Other: _____

BRAIN / IAC

☐ Headaches

☐ Seizures

☐ Weakness

☐ Trouble Walking

☐ Dizziness

☐ Speech Problems/Trouble Talking

☐ Hearing Problems ☐ Right ☐ Left

☐ Visual Problems ☐ Right ☐ Left

☐ Memory Loss

SPINE: Cervical / Thoracic / Lumbar

☐ Back Pain - Describe Below:

☐ Upper ☐ Middle ☐ Lower

☐ Neck Pain

☐ Weakness in:

☐ R Arm ☐ L Arm ☐ R Leg ☐ L Leg

☐ Pain in:

☐ R Arm ☐ L Arm ☐ R Leg ☐ L Leg

☐ Numbness in:

☐ R Arm ☐ L Arm ☐ R Leg ☐ L Leg

NECK (Soft Tissue)

☐ Lump or Mass

☐ Difficult Swallowing

☐ Difficulty Talking

☐ Pain

☐ Sore Throat

ABDOMEN

☐ Abdominal Pain - Describe Below:

☐ Sharp ☐ Dull ☐ Aching ☐ Burning

☐ Difficulty Swallowing

☐ Loss of Appetite

☐ Nausea / Vomiting

☐ Bowel or Bladder Changes

☐ Weight Loss or Gain

MALE PELVIS

☐ Pain

☐ Lump or Mass

☐ Trauma

☐ Pelvic Surgery

☐ Implant

☐ Hematuria

☐ Cancer

☐ Steroid or Radiation Therapy

FEMALE PELVIS

☐ Irregular Menstruation

☐ Painful Menstrual Cycles

☐ Painful Intercourse

☐ Hysterectomy

☐ Ovaries Removed

CHEST

☐ Difficulty Breathing

☐ Chest Tightness

☐ Chest Pain

☐ Moist Cough

☐ Dry Cough

☐ Heart Disease

INJURY / SURGICAL / RADIATION THERAPY

Did you injure the area of interest? ☐ YES ☐ NO If yes, describe: _____

Have you had past scans of the area we are scanning today? ☐ YES ☐ NO

If yes, approximately when was the scan done: _____ and at what facility: _____

Have you had previous surgery or radiation therapy on the area we are scanning today? ☐ YES ☐ NO

DO YOU HAVE….			TECHNOLOGIST NOTES:
Kidney disease or kidney injury?	☐ YES	☐ NO	_____
Kidney surgery, implant, single kidney?	☐ YES	☐ NO	_____
Are you on dialysis?	☐ YES	☐ NO	_____
Do you have diabetes?	☐ YES	☐ NO	_____
Do you have asthma?	☐ YES	☐ NO	_____

MRI CONTRAST

Have you ever had an allergic reaction to MRI Contrast? ☐ YES ☐ NO

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