

Name: _____ Date: _____

Medical History Information

What is the reason for your visit to our MRI facility today? What kind of problems are you experiencing? _____
experiencing? _____

How long have you had this problem? _____

Are your symptoms: Left sided _____ Right sided _____

Did an accident, fall or injury cause your symptoms? NO _____ YES _____ if yes, explain _____

Have you ever had surgery to this area? NO _____ YES _____ If yes, when _____

Did the surgery help? NO _____ YES _____

Have your symptoms come back? NO _____ YES _____

Same area? YES _____ NO _____ Please state new area _____

Have you had previous radiological exams done that relate to your current problem:

X-Rays NO _____ YES _____ Where? _____ When? _____

CAT Scan(s) NO _____ YES _____ Where? _____ When? _____

Bone Scan(s) NO _____ YES _____ Where? _____ When? _____

Ultrasound(s) NO _____ YES _____ Where? _____ When? _____

Angiogram(s) NO _____ YES _____ Where? _____ When? _____

MRI Scan (s) NO _____ YES _____ Where? _____ When? _____

Do you have any allergies? If yes, please list: _____

Have you ever had a reaction to contrast (dye) used for MRI or CT? NO _____ YES _____

If yes, please explain _____

Have you ever been diagnosed with cancer? NO _____ YES _____

If yes, to what part of your body? _____

What kind of treatment were you given? _____

When was your last treatment? _____

Do you have a history of any of the following:

Hypertension NO _____ YES _____

Diabetes NO _____ YES _____

Corticosteroid Use (Prednisone, Decadron) NO _____ YES _____

Renal Failure NO _____ YES _____

If yes, are you on dialysis: NO _____ YES _____

When is your next dialysis session: _____

***** Complete only the following section that pertains to your exam.*****

Brain:

Have you ever had a stroke or TIA? NO _____ YES _____ When? _____

If yes, have you recovered? Partially? _____ Fully? _____ Any other explanation _____

Have you ever had a seizure(s)? NO _____ YES _____ If yes, when was the last one _____

How long have you had seizures? _____

Do you know what kind of seizure(s) you had? (Grand Mal, Absence/Petite Mal, Partial/Complex Seizures)

Have you ever had brain surgery? NO _____ YES _____ If yes, When? _____ Explain _____

Do you have any hearing loss? NO _____ YES _____ If yes, which ear Right _____ Left _____ Both _____

Do you have any balance problems? NO _____ YES _____ If yes, explain _____

Do you have any vision problems? NO _____ YES _____ If yes, explain _____

Spine: What Level? Cervical _____ Thoracic _____ Lumbar _____

Have you has previous surgery to your spine? NO _____ YES _____ When? _____

What level of your spine was operated on? _____

Are you experiencing any bowel or bladder problems? NO _____ YES _____

Extremity: List body Region _____

Do you have any redness and/or tenderness at the problem site? NO _____ YES _____ If yes, explain _____

Have you had previous surgery to this area? NO _____ YES _____ When? _____