Questionnaire

Name: ______________________ Date: ____________ Age: ______

When seeing Dr. again: ________________________

Test due to symptoms from: (circle one)
Motor Vehicle Accident   On Job Injury   Personal Injury   Illness   Unknown

Date of injury: ______________________ Location of injury (County & State): ______________________

How long have you had symptoms? ______________________ Are you claustrophobic? ☐ Yes ☐ No

Why did you go to the doctor and why is he/she sending you here today? ______________________

____

Have you had surgery in the area we are scanning? ☐ Yes ☐ No If yes, what type of surgery? ____________

Location of surgery (hospital name): ______________________ Date of surgery? ____________

Have you had X-rays of the area we are scanning? ☐ Yes ☐ No If yes, date and facility: ____________

Have you had previous CT of the area we are scanning? ☐ Yes ☐ No If yes, date and facility: ____________

Have you had previous MRI of the area we are scanning? ☐ Yes ☐ No If yes, date and facility: ____________

Have you been diagnosed with cancer? ☐ Yes ☐ No If yes, what kind? ____________

Have you had radiation therapy? ☐ Yes ☐ No If yes, what kind and what body part? ____________

Are you pregnant, or is it possible that you are pregnant? ☐ Yes ☐ No

Are you diabetic? ☐ Yes ☐ No If yes, what diabetes medication do you take? ____________

What are your main symptoms? ______________________

____

Check all symptoms related to the type of MRI Scan you are having today

Abdomen

☐ Abdominal Pain - Describe below:
☐ Sharp ☐ Dull ☐ Aching ☐ Burning
☐ Difficulty Swallowing
☐ Appendectomy
☐ Loss of Appetite
☐ Nausea / Vomiting
☐ Bowel or Bladder Changes
☐ Weight Loss or Gain

Neck (Soft Tissue)

☐ Lump or Mass
☐ Difficulty Swallowing
☐ Difficulty Talking
☐ Pain
☐ Sore Throat

Male Pelvis

☐ Pain
☐ Lump or Mass
☐ Trauma
☐ Pelvic Surgery
☐ Implant
☐ Hematuria
☐ Cancer
☐ Prostate Cancer
☐ Steroid or Radiation Therapy

Female Pelvis

☐ Irregular Menstruation
☐ Painful Menstrual Cycles
☐ Painful Intercourse
☐ Hysterectomy
☐ Ovaries Removed

PLEASE TURN OVER

Check all symptoms related to the type of MRI Scan you are having today

Brain / IAC

- ☐ Headaches
- ☐ Seizures
- ☐ Weakness
- ☐ Trouble Walking
- ☐ Dizziness
- ☐ Speech Problem / Trouble Talking
- ☐ Hearing Problem ☐ Right ☐ Left
- ☐ Visual Problem ☐ Right ☐ Left
- ☐ Memory Loss
- ☐ MS
- ☐ Suspicion of MS
- ☐ Brain Surgery
- ☐ Paralysis or Stroke

Shoulder / Arm / Elbow / Hand / Hip / Leg Ankle / Foot / Knee / Finger / Wrist

- ☐ Right Body Part: ____________________
- ☐ Left Body Part: ____________________
- ☐ Limited Range of Motion
- ☐ Numbness
- ☐ Weakness
- ☐ Popping
- ☐ Grinding
- ☐ Stiffness
- ☐ Swelling
- ☐ Lump or Mass
- ☐ Pain - Describe below:
  - ☐ Sharp ☐ Dull ☐ Aching ☐ Burning

SPINE Cervical / Thoracic / Lumbar

☐ Back Pain - Describe below:

☐ Upper ☐ Middle ☐ Lower

☐ Dull ☐ Sharp ☐ Both

Neck Pain - Describe below:

☐ Dull ☐ Sharp ☐ Both

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

Chest

- ☐ Difficulty Breathing
- ☐ Moist Cough ☐ Dry Cough
- ☐ Heart Disease
- ☐ Mass

I attest that the information on this form is correct to the best of my knowledge. I have read and understand the contents of this form and had the opportunity to ask questions regarding the MR Procedure I am about to undergo.

Patient / Guardian Signature: ______________________________ **Today's Date:** ______________

FOR STAFF USE:

Screening Performed by: ☐ MR Technologist ☐ Nurse ☐ Radiologist ☐ Other: ____________________

Staff Signature: ______________________________ Print Name: ______________________________

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