PLEASANTON
DIAGNOSTIC IMAGING CENTER

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 ☐ Headaches ☐ Nausea ☐ Hearing loss

☐ Abdominal pain ☐ Blackouts ☐ Blurred vision ☐ Ringing in ears

☐ Pelvic Pain ☐ Dizziness ☐ Memory loss ☐ Seizures

☐ Back pain ☐ Neck pain ☐ Unexpected weight loss

☐ Shoulder pain - (☐ Right/☐ Left) ☐ Numbness - (☐ Right side/☐ Left side)

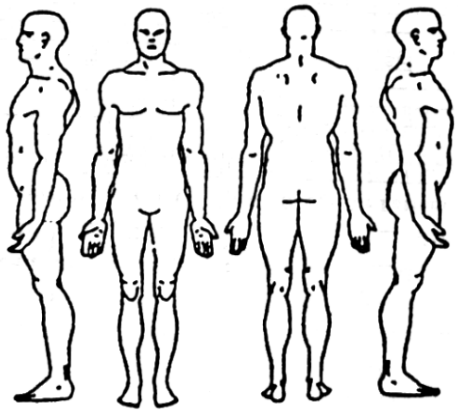
☐ Leg pain - (☐ Right/☐ Left) ☐ Weakness - (☐ Right side/☐ Left side)

☐ Arm pain - (☐ Right/☐ Left) ☐ Other: _____

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

_____

_____



LEFT FRONT BACK RIGHT

Please identify the location of any pain/numbness/lump

Medical History:

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

   ☐ Cancer ☐ Heart disease ☐ Kidney/renal disease ☐ Multiple myeloma ☐ Hypertension

   ☐ Seizures ☐ Sickle cell anemia ☐ Tumor, lump or mass ☐ Bleeding tendency ☐ Stroke

   ☐ Diabetes ☐ Congenital heart defect ☐ Glaucoma ☐ Heart arrhythmia

   ☐ Asthma, bronchitis or emphysema ☐ 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 on Part being imaged (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:

_____

_____

_____