PATIENT HISTORY QUESTIONNAIRE

PATIENT'S NAME: _____

DOB: _____ **AGE:** _____ **HEIGHT:** _____ **WEIGHT:** _____

SIGNATURE: _____ **DATE:** _____

Describe your symptoms or the reason for this study in detail. _____

_____

_____

_____

Insurance requires a specific date relating to this procedure in month day year format, please complete accordingly

Injury date___/___/_____ Follow up to surgery – list surgical date ___/___/_____ Follow up to known tumor ___/___/_____

If this is chronic pain, how long have you had your pain? _____ Specify the date of increase pain or new symptoms ___/___/_____

List ANY previous surgeries:

_____

_____

_____

_____

List all medications you are currently taking:

_____

_____

Please answer the following questions pertain to your personal history:

- Do you have any pacemakers, stents, artificial heart valves, aneurysm clips, IUD, hearing aids and/or any medical implants? No Yes
- **If you answered yes to the above question**, please note the item _____
- Are you wearing any transdermal patches (nitro/nicotine, birth control, etc)? No Yes
- Do you work with metal or has any metal been removed from your eyes? No Yes If yes, notify staff.
- Have you ever been wounded by a gun shot? No Yes If yes, was the bullet removed? No Yes
- Have you ever had a reaction to the MRI contrast? No Yes N/A
- Do you have a personal history of kidney problems? No Yes
- Do you have a personal history of diabetes? No Yes
- Do you have a personal history of high blood pressure? No Yes
- Do you have a personal history of asthma? No Yes
- Do you have a personal history of Sickle Cell disease? No Yes If yes, is it only the trait? No Yes
- Are you pregnant or breast feeding? No Yes N/A
- Do you have a personal history of cancer? No Yes If yes, what type? _____
- Are your symptoms injury related? No Yes If yes, how did the injury occur and what date? _____
- Have you had any previous diagnostic studies (i.e. X-ray; ultrasound; MRI; CT etc) of the same area we are scanning? No Yes If yes, what and where? _____