MRI SCREENING FORM

NAME: _____ **DATE:** _____

PHYSICIAN: _____ **EXAM:** _____

1. What symptoms are you having which pertain to you having this MRI?

		Pain in:	
_____	Headaches		
_____	Vision loss/Changes	_____	Arm (right/left)
_____	Dizziness	_____	Leg (right/left
_____	Numbness/weakness in arms or legs(right/left)	_____	Knee (right/left)
_____	Hearing loss (right/left)	_____	Lower back
_____	Ringing in ears (right/left)	_____	Upper back
_____	Change in bowel function	_____	Neck
_____	Change in bladder function	_____	Abdomen
_____	Lump or mass - Location: _____	_____	Foot (right/left)
_____	Swelling - Location: _____	_____	Hand (right/left)
_____	Other: _____	_____	Shoulder (right/left)

2. How long have you had these symptoms? _____

3. Is this the result of an injury? YES / NO If so, describe: _____

_____

4. Have you (past/present) been diagnosed as having cancer? YES / NO
   If so, please state name of cancer and location in your body: _____

5. Have you had chemotherapy? YES / NO If so, when and how many treatments? _____

6. Have you had radiation therapy? YES / NO If so, when and what body part? _____
   How many treatments? _____

7. Do you have high blood pressure? YES / NO

8. Are you diabetic? YES / NO

9. Have you had an MRI before? YES / NO If so, where? _____

   When? _____ Of what body part? _____

10. Have you had any previous surgeries? YES / NO If so, what kind and when? _____

_____

11. Did any of your surgeries involve leaving any metal in your body? YES / NO

**** Your exam will take a while. Please use the restroom now before having your scan ****

Patient Signature: _____ Date: _____