

**MRI Outpatient History Questionnaire**  
(Please Print)

This questionnaire is very important in helping the radiologist interpret your scan. **Please make every effort to answer each question as accurately and completely as possible.** If you have any questions please ask a staff member for assistance.

Name: \_\_\_\_\_ Date \_\_\_\_\_

Date of Birth \_\_\_\_\_ Height \_\_\_\_\_ Weight: (pounds) \_\_\_\_\_

Allergies: \_\_\_\_\_

Part of the body to be scanned: \_\_\_\_\_

Have you fallen in the last 3 months? \_\_\_\_\_

Do you have a condition called Nephrogenic Systemic Fibrosis? \_\_\_\_\_

Do you have a history of chronic kidney disease? \_\_\_\_\_ Are you currently undergoing dialysis? \_\_\_\_\_

Past Medical History: (heart disease, diabetes; asthma, epilepsy, high blood pressure) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Past Surgical History: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Have you ever had cancer? \_\_\_\_\_ If yes, what kind and has it spread to other areas? \_\_\_\_\_

\_\_\_\_\_

Are you having any symptoms in the area being scanned (such as pain, numbness, tingling weakness, clicking, grinding etc)? \_\_\_\_\_

\_\_\_\_\_

How long have you this problem and/or symptoms? \_\_\_\_\_

\_\_\_\_\_

Is this problem due to an injury? \_\_\_\_\_ If yes, describe in detail what happened and when it occurred.

\_\_\_\_\_  
\_\_\_\_\_



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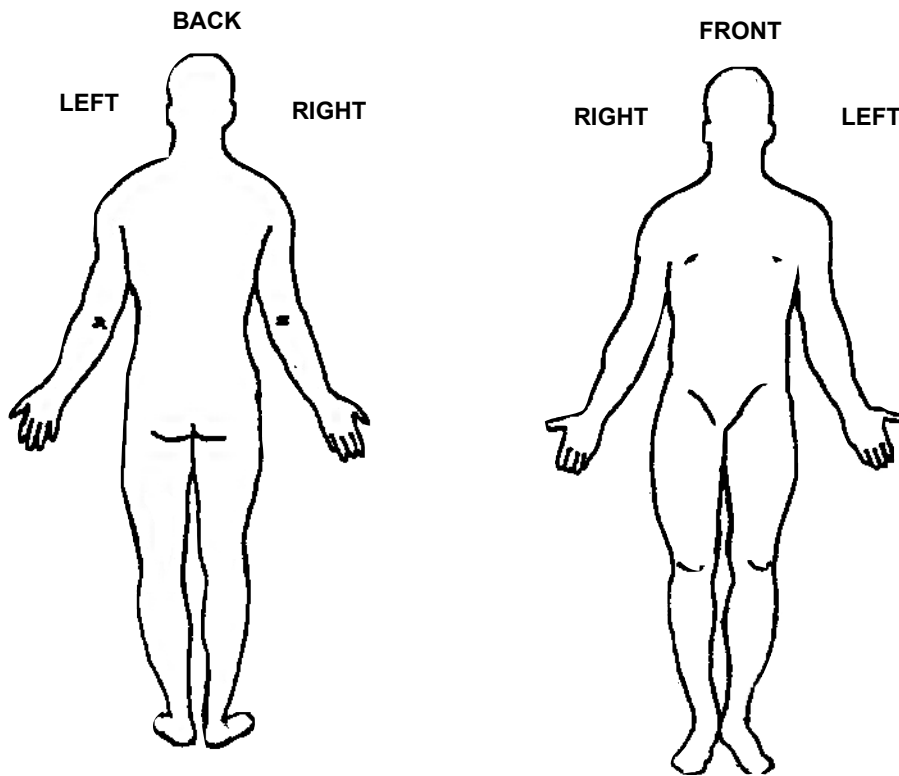
(Please Print)

Describe any other tests, surgeries or procedures you have had performed in the area that is being scanned. When and where were those procedures performed? \_\_\_\_\_

What did the above tests, surgeries or procedures show? \_\_\_\_\_

In your own words, why is this test being performed today? \_\_\_\_\_

Please indicate on the diagram below, the side or part of your body where you are experiencing symptoms:



Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Staff Signature \_\_\_\_\_ Date \_\_\_\_\_