HOAG MEMORIAL HOSPITAL PRESBYTERIAN

MRI OUTPATIENT QUESTIONNAIRE

CLINICAL HISTORY:

Briefly describe the symptoms you are having that prompted your physician to order this scan:

_____

_____

How long have you had these symptoms: # Days: _____ # Weeks: _____ # Months: _____ # Years: _____

Has the area that we are scanning today been subjected to injury? ☐ Yes ☐ No If yes, how long ago: _____

Have you ever had surgery on the area that is being scanned? ☐ Yes ☐ No

If yes, please describe when and what type of surgery? _____

Have you ever been diagnosed (past or present) with any of the following (please check):

☐ Cancer of _____ If yes, what was the date that you were diagnosed? _____

☐ Tuberculosis ☐ AIDS ☐ Hepatitis ☐ Multiple Myeloma ☐ Other: _____

CONTRAST STUDIES ONLY:

ALLERGIES:

Do you have any allergies to MR contrast? ☐ Yes ☐ No ☐ Unknown

If yes, what happened the last time you had MR contrast? _____

Do you have any allergies to latex? ☐ Yes ☐ No

List all other allergies: _____

KIDNEY DISEASE:

Do you have any kidney disease other than kidney stone? ☐ Yes ☐ No

Are you diabetic? ☐ Yes ☐ No If yes, are you receiving dialysis? ☐ Yes ☐ No

SYMPTOMS:

Complete only those questions below which relate to the type of MRI scan you are having:

BRAIN:		CHEST:	NECK (Soft Tissue):
☐ Headache	☐ Hearing problems	☐ Difficulty breathing	☐ Pain
☐ Numbness	☐ Visual problems	☐ Tightness in chest	☐ Mass/Lump present
☐ Seizures	☐ Trouble thinking	☐ Difficulty swallowing	☐ Difficulty swallowing
☐ Dizziness	☐ Trouble talking	☐ Cough	☐ Difficulty talking
☐ Weakness	☐ Trouble walking	☐ Pain	☐ Sore Throat

BODY:	FEMALE PELVIS:	SPINE:	TMJ:	ARMS/LEGS:
☐ Pain	☐ Irregular menstruation	☐ Pain - circle (Up/Mid/Low) (R/L)	☐ Pain - circle (Right / Left)	☐ Locking
☐ Nausea	☐ Painful menstruation cycle	☐ Weakness- circle (Up/Mid/Low) (R/L)	☐ Other (Clicking, Locking, Popping, Swelling)	☐ Clicking
☐ Vomiting	☐ Painful intercourse	☐ Numbness - circle (Up/Mid/Low) (R/L)		☐ Giving away
☐ Diarrhea				☐ Swelling
☐ Weight loss				☐ Pain
☐ Constipation				
☐ Yellowing skin				

Your signature denotes that all information given is true and correct. NOTE: Do not sign until all your questions/concerns have been answered.

Patient/Legal Representative: _____ Date: _____

If signed by other than patient, indicate relationship: _____

Reviewed By: _____ Date: _____