GREAT LAKES MRI

PATIENT HISTORY

NAME ______________________________ AGE __________ DATE__________________

EXAM ______________________________

1. HAVE YOU HAD A PREVIOUS MRI? __________ WHAT TYPE? _______________ WHEN? __________

2. PLEASE DESCRIBE YOUR SYMPTOMS PERTAINING TO THE MRI YOU ARE HAVING TODAY?

   ____

3. HOW LONG HAVE YOU HAD THESE SYMPTOMS? ______________________________

4. HAVE YOU SUSTAINED ANY INJURIES TO THE AREA THAT IS BEING SCANNED, PLEASE DESCRIBE:

   ____

   ____

5. IS THE MRI YOU ARE HAVING TODAY RELATED TO AN AUTO ACCIDENT OR WORK RELATED INJURY? IF YES, PLEASE PROVIDE THE CARRIER INFORMATION, DATE OF INJURY & INJURIES SUSTAINED:

   ____

   ____

6. HAVE YOU HAD ANY SURGERY TO THE AREA BEING SCANNED? YES _______ NO _______

   IF YES, PLEASE DESCRIBE ____

   ____

7. HAVE YOU EVER HAD ANY TYPE OF CANCER? ________ YES _________ NO

   IF YES, PLEASE DESCRIBE ____

   ____

8. DO YOU HAVE ANY DRUG ALLERGIES? ________ YES _________ NO

   IF YES, PLEASE DESCRIBE ____

9. ARE YOU ON ANY MEDICATIONS? _______ YES _______ NO

   IF YES, PLEASE LIST THEM ____

   ____

10. DO YOU HAVE ANY ALLERGIES? _______ YES ______NO IF YES, PLEASE DESCRIBE _______________

MRI SPINE

DO YOU HAVE ANY NUMBNESS ______ YES ______ NO IF YES, WHERE? ______________________
DO YOU HAVE ANY WEAKNESS ______ YES ______ NO IF YES, WHERE? ______________________
DO YOU HAVE ANY CHANGES IN BOWEL OR BLADDER HABITS ______ YES _____ NO

MRI BRAIN

DO YOU HAVE A HISTORY OF SEIZURES? _____ YES _____NO
DO YOU HAVE A HISTORY OF STROKE? _____YES _____ NO
IF YES, WHAT SIDE OF THE BODY WAS AFFECTED? _____ RIGHT _____ LEFT
DO YOU HAVE CHANGES IN VISION? _____ YES _____ NO
DO YOU HAVE BUZZING IN THE EAR? _____ YES _____ NO
IF YES, WHICH EAR? _____ RIGHT _____ LEFT
DO YOU HAVE DIZZINESS? _____ YES _____ NO

MRI UPPER/LOWER EXTREMITY

DO YOU HAVE WEAKNESS TO THE AREA BEING SCANNED? _____ YES _____ NO
DO YOU HAVE ANY SWELLING TO THE AREA BEING SCANNED? _____ YES _____ NO
DO YOU HAVE ANY DISCOLORATION TO THE AREA BEING SCANNED? _____ YES _____ NO

MRI OF TMJ JOINTS

DO YOU HAVE CLICKING SOUNDS WHEN YOU OPEN YOUR MOUTH? _____ YES _____ NO
CAN YOU OPEN YOUR MOUTH NORMALLY? _____ YES _____ NO
ANY HISTORY OF ORTHODONTICS (I.E. BRACES)? _____ YES _____ NO
ARE YOU EXPERIENCING JAW PAIN? _____ YES _____ NO

MRI ABDOMEN/PELVIS

HAVE YOU EVER HAD ANY PROBLEMS WITH THE FOLLOWING?
PLEASE CHECK ALL THAT APPLY.

MALE

LIVER/SPLEEN _____
PANCREAS _____
KIDNEYS _____
BLADDER _____
G I TRACT _____
PROSTATE _____
TESTICLES _____

FEMALE

LIVER/SPLEEN _____
PANCREAS _____
KIDNEYS _____
BLADDER _____
G I TRACT _____
UTERUS/OVARIES _____
LAST MENSTRUAL PERIOD
____

IF YES, PLEASE DESCRIBE ____

____