

**HEALTH HISTORY QUESTIONNAIRE FOR MRI**

**PATIENT NAME:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**DATE OF BIRTH:** \_\_\_\_\_ **HEIGHT:** \_\_\_\_\_ **WEIGHT:** \_\_\_\_\_

**REFERRING PHYSICIAN:** \_\_\_\_\_

**WHAT ARE WE SCANNING?:** \_\_\_\_\_

**What symptoms are you having with the area that is to be scanned?**

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

**How long have you had these symptoms?** \_\_\_\_\_

**Is the problem that you are having related to an accident or injury?** 0 Yes 0 No

**If yes, when did this occur and briefly describe what happened?**

\_\_\_\_\_

**Have you had any surgery on this area?** 0 Yes 0 No

**If yes, what type of surgery did you have and when was it performed?**

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

**What has your surgeon told you may be wrong with the area being scanned?**

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

**Have you had any x-rays or other types of diagnostic tests performed on this area?**

0 Yes 0 No **If yes, what kind and where were they performed?**

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

\_\_\_\_\_  
**Patient or Parent/Legal Guardian Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Witness:**