

FOX VALLEY ORTHOPAEDIC INSTITUTE MRI PATIENT HISTORY

Account # _____

Date of exam: _____

Patient Name: _____ DOB: _____ Age: _____

Height: _____ Weight: _____ Ordering Dr. _____

1. What body part are you having examined? _____ Right Left

2. Why are you having this exam? (symptoms): _____

3. How long have you had your symptoms? _____

4. Are your symptoms a result of an accident or injury? YES NO
If yes, describe how your injury occurred: _____

5. Check all symptoms that apply to today's visit:

_____ Pain
_____ Swelling
_____ Bruising
_____ Mass/lump
_____ Numbness

_____ Weakness
_____ Locking of joint
_____ Clicking/Popping
_____ Loss of bladder function
_____ Loss of bowel function

Head exams:
_____ Dizziness
_____ Headache
_____ Hearing loss R/L
_____ Blurred vision
_____ Ringing in ears

6. Have you had a steroid injection in the area to be examined? YES NO
If yes, when was your last injection? _____

7. Have you had surgery in the area to be examined? YES NO
If yes, please list dates and type of surgery _____

8. Do you have a history of cancer? YES NO When: _____ Type: _____
Did you receive radiation therapy? YES NO
Did you receive chemotherapy? YES NO

9. Have you been diagnosed with arthritis? YES NO Type: _____

10. Do you have any allergies or asthma (circle)? YES NO
If yes, list: _____
What was your reaction to the allergy? _____
Have you been hospitalized due to any allergic reaction? YES NO
Do you carry an epinephrine pen due to allergies? YES NO

11. Do you have high blood pressure or diabetes? Circle which one(s). YES NO

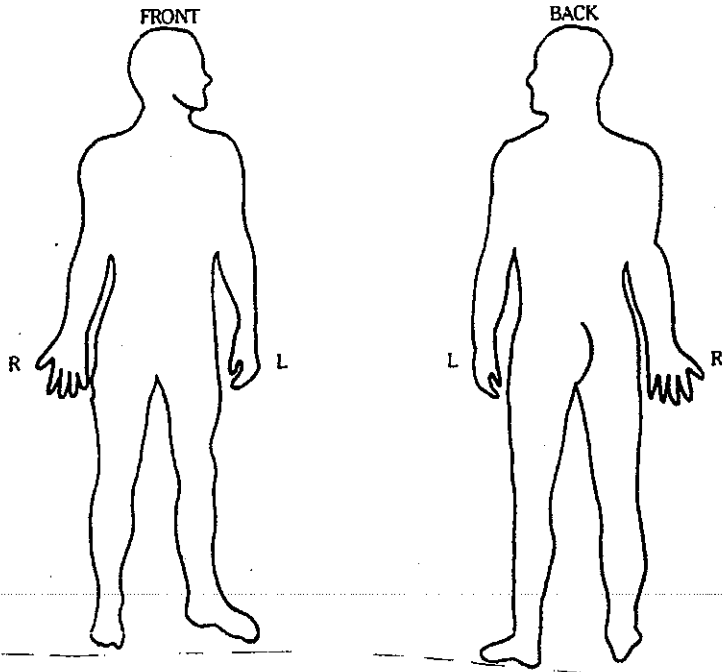
12. Do you have a history of kidney or liver disease? Circle which one(s). YES NO

Brain or Cervical exams only:

13. Do you have a history of seizures? YES NO Last seizure? _____
14. Have you had a stroke? YES NO When: _____
15. Have you been diagnosed with multiple sclerosis? YES NO When: _____

Please turn over this page and indicate on the drawing the area(s) of your symptoms.

MARK WHERE YOUR SYMPTOMS ARE WITH AN "O".



17. Have you had any prior diagnostic imaging study or examination related to today's exam?
Please circle: YES NO

If yes, please circle all exams that apply.

X-RAY CTSCAN MRI Ultrasound Myelogram Bone Scan

What facility? _____

When? _____

TO BE COMPLETED BY THE MRI TECHNOLOGIST

Department Information:

When

Where

Previous Pertinent MRI Exams? _____

Previous Pertinent CT Exams? _____

Previous Pertinent XR Exams? _____

Previous Pertinent US Exams? _____

Previous Pertinent NM/PET Exams? _____

Technologist's scan notes: _____

Gad lot:	GAD exp:	GAD amount:
Omnipaque lot:	Omnipaque exp:	Omnipaque amount:
Lido lot:	Lido exp:	Lido amount:
RAD:	TECH:	Fluoro time:
Injection site:	IV or intra-articular	Time:
Creatinine:	GFR:	Time:

Shielded: YES NO

Technologist's Signature: _____