MRI History Sheet

Name________________________________ Date_________________ DOB_________________

General Background

1. What complaints or symptoms led you to seek medical care?
____
2. How long have you had these symptoms? ____________________________________
3. Have you had previous MRI or CT studies? If yes, when, where, and why?
____
4. Have you been diagnosed with cancer? If yes, what kind and have you received radiation therapy and/or chemotherapy?
____

MRI of the Brain

1. Have you experienced nausea/vomiting? Y N
2. Do you have hearing loss? Y N
3. Do you have headaches? Y N
4. Are you experiencing numbness in your face? Y N
5. Do you have gait disturbance? Y N
6. Have you experienced any visual disturbances? Y N
7. Have you had a head injury? Y N
8. Have you had any seizures? Y N
9. Have you had any previous neurological problems? If yes, please describe.
____

MRI of Thoracic/Lumbar-Lumbo Sacral Spine

1. Do you have low back pain? Y N
2. Do you have any weakness of the right leg? Y N
3. Do you have any weakness of the left leg? Y N
4. Do you have difficulty raising or lowering your foot? Y N
5. Do you have bowel/bladder problems? Y N
6. Have you had a myelogram? Y N
7. Have you had previous back surgery? Y N
8. Do you have pain, numbness or tingling in any of the following areas? Please check the appropriate selections.

Location Right Left
Buttocks
Front of Thigh
Back of Thigh
Calf
Foot/Big Toe
Foot/Small Toe

____

MRI of Cervical Spine

1. Do you have low back pain? Y N
2. Do you have any weakness of the right arm? Y N
3. Do you have any weakness of the left arm? Y N
4. Do you have any bowel/bladder problems? Y N
5. Have you had a myelogram? Y N
6. Have you had previous neck surgery? Y N
7. Do you have pain, nubness or tingling in any of the following areas? Please check the appropriate selections?

Location Right Left
Shoulder
Upper Arm

Lower Arm
Finger (specify 1st, 2nd, 3rd, 4th,5th)

MRI History Sheet Continued
MRI of Joints/Extremeties
1. Is there swelling of the affected limb or joint? Y N
2. Do you have poor range of motion? Y N
3. Are you experiencing any pain in the area? Y N
4. Did an accident cause this problem? Y N
5. Have you had previous surgery in this area? Y N

MRI of TMJ
1. Do you have difficulty opening/closing your mouth? Y N
2. What gives you greater difficulty, opening or closing? O C
3. Is it painful when you chew food? Y N
4. What side is more painful? R L
5. Do you experience clicking? Y N
6. Does clicking occur when your mouth is half or wide open? H W
7. What side does the clicking occur on? R L
8. Has your jaw ever locked open or closed? Y N
9. Have you had an injury to the jaw? Y N
10. Do you wear an appliance? Y N