BAY RADIOLOGY San Ramon

Patient History Questionnaire (MRI)

Patient Account Number: _____

Print Name: _____ Date: _____

Reason for Procedure

Please check any of the following symptoms that you are experiencing:

☐ Chest Pain ☐ Headaches ☐ Nausea ☐ Hearing Loss

☐ Abdominal Pain ☐ Blackouts ☐ Blurred Vision ☐ Ringing in Ears

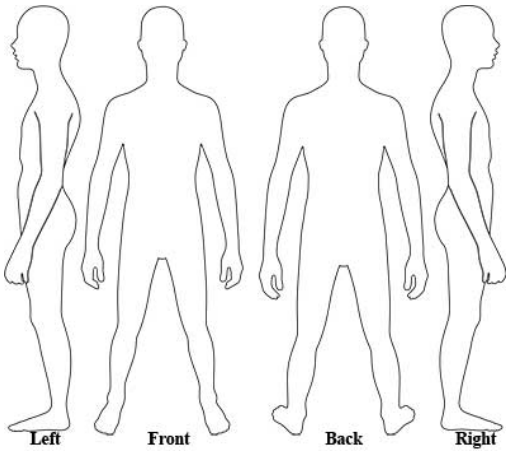
☐ Pelvic Pain ☐ Dizziness ☐ Memory Loss ☐ Seizures

☐ Back Pain ☐ Neck Pain ☐ Unexpected Weight Loss

☐ Shoulder Pain ☐ Left ☐ Right Side ☐ Numbness ☐ Right Side ☐ Left Side

☐ Leg Pain ☐ Left ☐ Right ☐ Weakness ☐ Right Side ☐ Left Side

☐ Arm Pain ☐ Left ☐ Right ☐ Other: _____



How and when did these symptoms occur (e.g.) injury, just started, etc.)? _____

_____

_____

Medical History

1. Do you have or have you had any of the following?

☐ Cancer ☐ Heart Disease ☐ Kidney/Renal Disease ☐ Multiple Myeloma ☐ Hypertension

☐ Seizures ☐ Sickle Cell Anemia ☐ Tumor, Lump or Mass ☐ Bleeding Tendency ☐ Heart Arrhythmia

☐ Diabetes ☐ Congenital Heart Defect ☐ Glaucoma ☐ Stroke

☐ Asthma, Bronchitis, or Emphysema ☐ Other Illness/Disease: _____

2. Have you had any tests (MRI, CT, C-Ray, etc.) performed for the symptoms you are currently experiencing? ☐ Yes ☐ No

   If yes, please list the date, type and who performed the test: _____

   _____

3. Have you had any surgeries or therapies (e.g., radiation therapy, chemotherapy, etc.)? ☐ Yes ☐ No

   If yes, please list the date and type of surgery or therapy: _____

   _____

4. Are you currently taking any medications? ☐ Yes ☐ No

   If yes, please list all medications you are currently taking: _____

   _____

5. Do you have any allergies, (e.g., medications, latex, food, etc.)? ☐ Yes ☐ No

   If yes, please list all allergies: _____

   _____

I hereby certify that the above information is true and correct to the best of my knowledge.

_____ _____ _____

Patient or Legal Representative Signature | Print Name (and Authority if Legal Representative) | Date

Technologists Notes: _____

_____

_____

_____

Revised October 2014