

YOUR SITE NAME HERE
YOUR ADDRESS HERE
CITY, STATE
PHONE (954) 698-9399

FOLLOWUP APPT
DATE: _____
TIME: _____

●PATIENT INFORMATION SHEET FOR MRI●

Patient: _____ File #: _____

Referring MD: _____ DOB: _____

Type of MRI: _____ Date: _____

Diagnosis: _____

1. What is the patient's chief complaint? _____

2. What caused the patient to see the doctor for this problem? _____

3. What does the doctor think is causing the problem? _____
Clinical History: _____

4. Describe the patient's pain: _____
A. Does anything make it worse: _____
B. Does anything make it better: _____
C. Where is the pain located: _____

5. Does the patient have any weakness? _____

6. **Has the patient ever injured the area being scanned before? Y / N Circle one**
If yes, when and how? _____

7. Has the patient ever broken any bones in their _____ before? _____

8. **Has the patient ever had surgery on the area being scanned. If so, what kind and when** _____

Please submit operative reports when applicable

9. Does the patient have arthritis in any of their joints? _____

10. Does the patient have any other medical conditions? _____

11. Describe the patient's health: _____

MRI Tech: _____