Anaheim Hills Imaging Center

MRI Procedure Questionnaire

Last Name:	First Name:	MRN: Secondary MRN:

Date of Exam:	Date of Birth:	Weight:	Referring physician:

Previous Imaging: (**Related to TODAY'S VISIT ONLY**)

MRI ☐ No ☐ Yes, If yes, Where: _____ When: _____

CT ☐ No ☐ Yes, If yes, Where: _____ When: _____

Why did your doctor order this test? _____

_____

Describe location of pain: _____

Have you had an injury / fall? ☐ No ☐ Yes If yes, when did it happen? _____

Please describe how it happened: _____

Weakness? Where? _____ How long? _____

Numbness/tingling? Where? _____ How long? _____

Personal Medical History:

History of Cancer ☐ No ☐ Yes, If yes, Type: _____

Radiation / Chemotherapy ☐ No ☐ In Progress ☐ Completed, When: _____

Previous Surgery (**Related to TODAY'S VISIT ONLY**) ☐ No ☐ Yes If yes, Date of surgery: _____

Type of Surgery / Describe: _____

Your signature below indicates (1) that the information you have provided on this form is true and accurate; (2) that you have received all the information that you desire concerning the diagnostic imaging procedure; and (3) that you authorize and consent to the performance of the diagnostic imaging procedure.

_____ _____

Signature (patient/guardian) Date

If signed by other than patient, please indicate relationship _____

For Office Use Only- Do Not Write Below

Exam(s) Performed: _____ ☐ Previous available for comparison

☐ **STAT Report Required**

☐ Arthrogram Injection: Performed by: _____

☐ IV Injection: Vial amount opened _____ ml Contrast: _____ cc ProHance

☐ Right ☐ Left _____ (location) Injected by: _____

Complications: ☐ Yes ☐ No GFR: _____ Drawn Date: _____

Tech Notes: _____

Technologist Name: _____