



# Premier Medical Clinic MRI Patient History

Todays Date: \_\_\_\_\_ Exam: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Sex: \_\_\_\_\_ M \_\_\_\_\_ F Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Pregnant: \_\_\_\_\_ Yes \_\_\_\_\_ No

Ordering Physician: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

Do you have or have you ever had:

Cardiac Pacemaker	YES	NO	Any type of Stent	YES	NO
Eye Surgery	YES	NO	Heart Valve	YES	NO
Metal Fragments	YES	NO	Hearing Aid	YES	NO
Dentures	YES	NO	Removable Dentures	YES	NO
Bullets	YES	NO	Metal in Eyes	YES	NO
Metal Joints	YES	NO	Bone Screws	YES	NO
Brain Surgery	YES	NO	Intra Uterine Device (IUD)	YES	NO
Metal Implants	YES	NO	Neurostimulator (Tens Unit)	YES	NO
Any Medical Device in your Body that Contains Metal				YES	NO

Describe your symptoms: \_\_\_\_\_

A. Where does it hurt? \_\_\_\_\_

B. Does the pain radiate/travel to another area? \_\_\_\_\_  
Where? \_\_\_\_\_

C. Do you have numbness or tingling? \_\_\_\_\_ Where? \_\_\_\_\_

D. Is this condition the result of an injury? \_\_\_\_\_  
Describe How and When? \_\_\_\_\_

Have you had surgery in the area being scanned? \_\_\_\_\_

Have you ever had a prior X-ray, CT or MRI of the area being imaged today? \_\_\_\_\_  
When and Where? \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient History:

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\_\_\_\_\_  
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