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MRI PATIENT HISTORY FORM

Patient Name ____________________________________ **Date** __________________

Type of Exam ____

Please Give a Description of Your Pain or Symptoms: ___________________________

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Have you had an Injury to the area being scanned? Yes _________ **No** _________

Do You Have Any of The Following? If So, Where?

	Yes	No	Where
Pain	_________	__________	____________________
Numbness	_________	__________	____________________
Tingling	_________	__________	____________________
Weakness	_________	__________	____________________

Have You Had any Surgery to the Area Being Scanned? Yes _________ **No** __________
When?__________________________
Was There Improvement? Yes _______ **No** _________

Do You Have Any History of Cancer? Yes __________ **No** __________
Where?__________________________
What Treatments Have You Had?____

Have you had Any of These Exams?

	Yes	No	When
MRI	_________	__________	____________________
CT	_________	__________	____________________
Ultrasound	_________	__________	____________________
PET Scan	_________	__________	____________________
Nuclear Medicine	_________	__________	____________________

Patient Signature____ **Date**______________________

WellStar Health System
☐Cobb ☐Cobb Imaging Ctr. ☐Douglas ☐Kennestone
☐210 Bldg. ☐700 Bldg. ☐ECI ☐TLI ☐Paulding
☐Windy Hill

MRI Patient History Form

PATIENT IDENTIFICATION