MRI HISTORY FORM

Name: _____ DOB: _____ Date: _____

Have you ever had surgery in the area being scanned? ☐Yes ☐No

Describe: _____

Have you ever had an MRI on the area being scanned? ☐Yes ☐No

When: _____ Where: _____

Do you have a history of cancer? ☐Yes ☐No

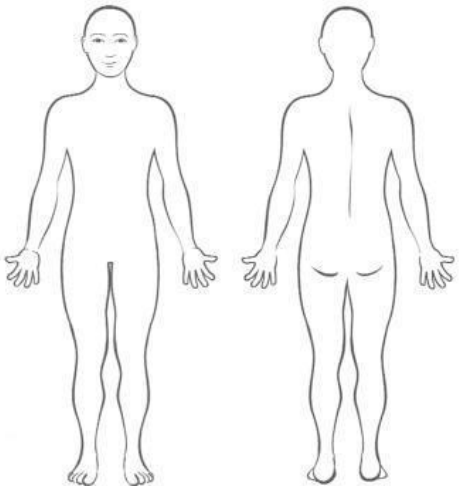
Describe: _____

Was this a result of an injury? ☐Yes ☐No

Details:_____

Date of onset: _____

Please Label



Symptoms

- Pain ☐
- Numbness ☐
- Weakness ☐
- Tingling ☐
- Burning ☐
- Instability ☐
- Swelling ☐
- Limited Range of Motion ☐
- Popping/Clicking/Grinding ☐
- Headaches/Migraines ☐
- Nausea/Vomiting ☐
- Dizziness/Vertigo ☐
- Vision loss/Double vision/Blurry vision ☐
- Hearing loss ☐
- Tinnitus ☐
- Difficulty speaking ☐
- Head pressure ☐
- Seizures ☐
- Memory loss ☐
- Confusion ☐
- Fogginess ☐
- Other: _____ ☐

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Notes:

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Tech use only:

☐ E.P.R. ☐E.P.I. ☐Send cd/report to another provider: _____