

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ DOB/Age \_\_\_\_\_  
 Ht. \_\_\_\_\_ Wt. \_\_\_\_\_ Allergies \_\_\_\_\_ PT# (Internal) \_\_\_\_\_

**REASON FOR EXAM** (Please include symptoms and time frame):  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**TECH NOTES** (for internal use only):

<b>Sedation:</b>	
<b>MRI Safety:</b>	
vial Guerbet Dotarem	vial Bayer Eovist
_____ from _____	_____ from _____
<b>Additional Notes:</b>	
_____	
_____	
_____	

Previous Imaging Studies Related to Todays Exam	Date
Previous Surgeries Related to Todays Exam	Date

Is your area of concern related to an injury?  Yes  No If yes, continue below:  
 Date of Injury \_\_\_\_\_ How were you injured?  Car Accident  Work  Other  
 Describe Injury (please be specific) \_\_\_\_\_

Have you ever been diagnosed with Cancer?  Yes  No If yes, continue below  
 What type of cancer? \_\_\_\_\_ Location: \_\_\_\_\_  
 Date diagnosed: \_\_\_\_\_ Current status:  Newly Diagnosed  Remission  Recurrence  
 Treatment:  Surgery  Radiation  Chemo  Other treatment(s): \_\_\_\_\_  
 Date of Last Treatment: \_\_\_\_\_ Has it spread?  Yes  No If yes, where? \_\_\_\_\_  
 Is your visit today related to this cancer?  Yes  No

**Please complete below for all that apply:**

	Where? <i>Example: Abdomen</i>	How Long? <i>Example: 2 weeks</i>
Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Mass	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Infection	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Have you ever had Renal Failure/Dialysis?  Yes  No If yes, when? \_\_\_\_\_  
**WOMEN ONLY BELOW:**  
 Have you had a Hysterectomy?  Yes  No If yes, when? \_\_\_\_\_  
 Have you had your ovaries removed?  No  Right  Left  Both If yes, when? \_\_\_\_\_

I agree that the above information is correct (Do not fill out until after technologist has reviewed):  
 Patient Signature: \_\_\_\_\_ Todays Date: \_\_\_\_\_