

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):

Sedation:	_____
MRI Safety:	_____
Guerbet Dotarem Contrast: _____ from _____ vial	
Additional Notes: _____ _____ _____ _____	

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 the below for all that apply:	Where?		How Long?
	Example: Left Shoulder		Example: 2 years
Joint pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Weakness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Loss of Range of Motion	<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 had any Joint Injections in the past? Yes No If yes, When? _____
 Location of injection(s): _____

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