SDMI STEINBERG DIAGNOSTIC

INTAKE QUESTIONNAIRE
MRI ADVANCED BODY IMAGING

First Name _____ Last Name _____ DOB/Age _____

Allergies/Include reaction(s): _____.

Height: _____ Weight: _____ Patient# (*Internal Use Only*): _____

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

Previous Imaging Studies Related to Todays Exam	Date

Previous Surgeries Related to Todays Exam	Date

TECH NOTES *(for internal use only)*:

Sedation:	
MRI Safety:	
vial Guerbet Dotarem _____from_____	**vial Bayer Eovist** _____from_____
Additional Notes:	

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?** *Example: Abdomen*	**How Long?** *Example: 2 weeks*
Pain	☐ **Yes** ☐ **No**		
Mass	☐ **Yes** ☐ **No**		
Infection	☐ **Yes** ☐ **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: _____