SDMI STEINBERG DIAGNOSTIC

INTAKE QUESTIONNAIRE
MRI HEAD/SINUS 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:	

Guerbet Dotarem Contrast:

_____ from _____ **vial**

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**

Are you experiencing any numbness/tingling? ☐ **Yes** ☐ **No** **If yes, where?** _____

Are you currently experiencing or have you ever experienced any of the following?

HEAD		**How long?** *(ex: 1 month)* **or when?** *(ex: Aug, 2020)*			**How long?** *(ex: 1 month)* **or when?** *(ex: Aug, 2020)*
Stroke	☐ **Yes** ☐ **No**		**Sinus Infection**	☐ **Yes** ☐ **No**	
Memory Loss	☐ **Yes** ☐ **No**		**Facial Pain**	☐ **Yes** ☐ **No**	
Tremor	☐ **Yes** ☐ **No**		**Congestion/Runny Nose**	☐ **Yes** ☐ **No**	
Dizziness	☐ **Yes** ☐ **No**		**Sore Throat**	☐ **Yes** ☐ **No**	
Seizures	☐ **Yes** ☐ **No**		**Toothaches**	☐ **Yes** ☐ **No**	
MS Diagnosis	☐ **Yes** ☐ **No**		**Post Nasal Drip**	☐ **Yes** ☐ **No**	
Hemorrhage	☐ **Yes** ☐ **No**		**Chronic Cough**	☐ **Yes** ☐ **No**	
Headaches	☐ **Yes** ☐ **No**		**Nose Bleeds**	☐ **Yes** ☐ **No**	
Migraines	☐ **Yes** ☐ **No**		**Deviated Septum**	☐ **Yes** ☐ **No**	
Vision Loss	☐ **Yes** ☐ **No**		**Snoring/Sleep Apnea**	☐ **Yes** ☐ **No**	
Hearing Loss	☐ **Yes** ☐ **No**		**Sinus Surgery**	☐ **Yes** ☐ **No**	

I agree that the above information is correct *(Do not fill out until after technologist has reviewed):*

Patient Signature: _____ Todays Date: _____