

MRI OUTPATIENT QUESTIONNAIRE

Patient Name: _____

Briefly describe the symptoms you are having that prompted your physician to order this scan:

How long have you had those symptoms? # Days: _____ # Weeks: _____ # Months: _____ # Years: _____

Has the area that we are scanning today been subjected to injury? Yes No If Yes, how long ago: _____Have you ever had surgery on the area that is being scanned? Yes No

If yes, please describe when and what type: _____

Have you ever been diagnosed (past or present) with any of the following? (please check)

 Cancer Tuberculosis AIDS Hepatitis Other infectious disease: _____

Have you had any of the below symptoms over the past month? (please check)

 Fever Night sweats Fatigue Unintentional weight loss Loss of appetiteBriefly describe your past medical history: _____
_____**Complete only those questions below which relate to the type of MRI scan you are having.**

<input type="checkbox"/> BODY: <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Difficulty urinating <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody stools <input type="checkbox"/> Bloody urine	<input type="checkbox"/> BRAIN: <input type="checkbox"/> Headaches <input type="checkbox"/> Seizures <input type="checkbox"/> Weakness <input type="checkbox"/> Trouble walking <input type="checkbox"/> Trouble talking <input type="checkbox"/> Trouble thinking <input type="checkbox"/> Dizziness <input type="checkbox"/> Speech problems <input type="checkbox"/> Hearing problems: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Visual problems: <input type="checkbox"/> Right <input type="checkbox"/> Left	<input type="checkbox"/> FEMALE PELVIS: <input type="checkbox"/> Irregular menstruation <input type="checkbox"/> Painful menstrual cycles <input type="checkbox"/> Painful intercourse Have you had a hysterectomy? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you still have your ovaries? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> ARMS/LEGS: <input type="checkbox"/> Locking <input type="checkbox"/> Clicking <input type="checkbox"/> Giving away <input type="checkbox"/> Swelling <input type="checkbox"/> Pain	<input type="checkbox"/> CHEST: <input type="checkbox"/> Difficulty breathing <input type="checkbox"/> Pain <input type="checkbox"/> Tightness in chest <input type="checkbox"/> Moist cough <input type="checkbox"/> Dry cough	<input type="checkbox"/> TMJ: <input type="checkbox"/> Clicking <input type="checkbox"/> Locking <input type="checkbox"/> Popping <input type="checkbox"/> Swelling <input type="checkbox"/> Difficulty opening jaw <input type="checkbox"/> Pain: <input type="checkbox"/> Right <input type="checkbox"/> Left
<input type="checkbox"/> NECK (Soft Tissue): <input type="checkbox"/> Mass/Lump present <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Difficulty talking <input type="checkbox"/> Pain <input type="checkbox"/> Sore throat	<input type="checkbox"/> SPINE: CERVICAL/THORACIC/LUMBAR: <input type="checkbox"/> Weakness in: <input type="checkbox"/> Right Arm <input type="checkbox"/> Left Arm <input type="checkbox"/> Right Leg <input type="checkbox"/> Left Leg <input type="checkbox"/> Pain in: <input type="checkbox"/> Right Arm <input type="checkbox"/> Left Arm <input type="checkbox"/> Right Leg <input type="checkbox"/> Left Leg <input type="checkbox"/> Numbness in: <input type="checkbox"/> Right Arm <input type="checkbox"/> Left Arm <input type="checkbox"/> Right Leg <input type="checkbox"/> Left Leg <input type="checkbox"/> Back Pain: <input type="checkbox"/> Upper <input type="checkbox"/> Mid <input type="checkbox"/> Low <input type="checkbox"/> Pain Quality: <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Both <input type="checkbox"/> Neck Pain: <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Both	

MRI OUTPATIENT QUESTIONNAIRE**Radiology Department**

PS 4255

Side 1 of 2

07/28/09



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