

MAGNETIC RESONANCE IMAGING PRE-IMAGING SURVEY



To be completed by Patient and checked by Technologist

Where is the area of concern? Was there a specific cause or event?
Briefly describe your symptoms.

Have previous X-Rays or scans been performed on the area of concern?
Please specify scan and area below.

CT SCAN
MRI
NUCLEAR MEDICINE

ULTRASOUND
X-RAY
OTHER _____

If so, where? _____
when? _____

Have you had previous surgery of any kind to the area to be examined, including arthroscopy
(Scope)? Specify date of surgery and the location of the scar.

Previous History (Please Check)

CANCER: TYPE _____ TREATMENT _____

- ARTHRITIS
- SPINE PROBLEM
- NEUROLOGICAL DISEASE (MS; FIBROMYALGIA)
- DIABETES
- HEART DISEASE
- LIVER OR KIDNEY DISEASE
- OTHER (SPECIFY)

Technologist Comments:

Patient Initials _____

Date _____

Tech Initials _____