RIVER OAKS
MRI & DIAGNOSTIC

MRI Brain Scan Patient History

Patient Name: _____ DOB: _____ Age: _____
Height/Weight: _____ MRN: _____Accession #:_____

-Please list all symptoms that prompted your MRI: _____
_____
-Approximate date of onset of symptoms: _____
-Any history of dizziness: Yes ____ No ____ Since when: _____
-Any hearing loss: Yes ____ No ____ If Yes, which side? Left ____ Right ____

-Have you been diagnosed with cancer? Yes ____ No ____ Type: _____
-If so, have you had chemotherapy? Yes ____ No ____
-Radiation? Yes ____ No ____

-Please list any surgical procedures, operations you have had: _____
_____

-Is there any history of weakness and if so which side: Left ____ Right ____
-Is there any history of numbness and if so which side: Left ____ Right ____
-Is there any history of seizures, past or present? Yes ____ No ____
-Is there any history of trauma, accidents and if so when? _____
-Is there a history of memory loss or forgetfulness? _____

-Have you had any previous diagnostic imaging of the affected area? _____Yes _____No
-If yes, please list below:
Date: _____ Type: _____ Facility: _____
Date: _____ Type: _____ Facility: _____
-Do you have the report or images with you? _____Yes _____No

I attest that the above information is correct to the best of my knowledge. I read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and regarding the MR procedure that I am about to undergo.

Patient/Guardian Signature: _____ Date: _____

OFFICE USE ONLY
Creatinine: _____ GFR(mL/min): _____ Contrast order verified: ____Yes ____No
Contrast used: _____ Contrast amount: _____
IV Location: _____ Inserted by: _____
Expiration Date: _____ Lot # _____
Extravasations: _____Yes _____No
Tech Notes: _____
_____
_____

Tech Initials: _____ Date: _____
Paramedic Initals: _____ Date: _____