PROHEALTH
Advanced Imaging
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PATIENT HISTORY QUESTIONNAIRE (MRI)

Patient Signature: _____ Date: _____

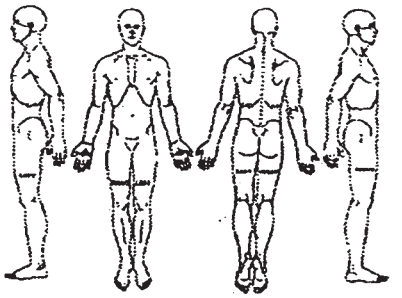
Referring Doctor: _____ DOB: _____ Sex: _____ Weight: _____

This questionnaire is designed to assist us in determining if it is safe for you to undergo a magnetic resonance imaging procedure that you answer all of the following questions. Id you don't understand any question, please ask for assistance.

REASON FOR PROCEDURE:

Please check any of the following symptoms that ou are experiencing:

- ☐ Chest Pain ☐ Headaches ☐ Nausea ☐ Hearing Loss
- ☐ Seizures ☐ Blackouts ☐ Blurred Vision ☐ Ringing in ears
- ☐ Pelvic Pain ☐ Dizziness ☐ Memory Loss ☐ Abdominal Pain
- ☐ Back Pain ☐ Neck Pain ☐ Unexpected weight Loss
- ☐ Shoulder Pain - (☐ Right/ ☐ Left) ☐ Arm Numbness - (☐ Right/ ☐ Left)
- ☐ Arm Pain - (☐ Right/ ☐ Left) ☐ Arm Weakness - (☐ Right/ ☐ Left)
- ☐ Leg Numbness - (☐ Right/ ☐ Left) Leg Pain - (☐ Right/ ☐ Left)
- ☐ Leg Weakness - (☐ Right/ ☐ Left) Hip Pain- (☐ Right/ ☐ Left)
- ☐ Other:_____



Please identify the location of any pain/numbness/lump

Reason you are here today? (Explain your medical problem in detail…) What is the problem? Where is the problem? How long have you had this problem?

_____

_____

Is your problem related to an injury? ☐ Yes ☐ No If yes, Date of Injury?_____
How Injured? ☐ MVA ☐ Work ☐ Other (please explain) _____

MEDICAL HISTORY:

1. Do you have or have had any of the following?

- ☐ Cancer, Type_____ ☐ Hearth Disease ☐ Kidney/renal disease ☐ Multiple Myeloma ☐ Hypertension
- ☐ Multiple sclerosis ☐ Seizures ☐ Sickle cell anemia ☐ Tumor, lump or mass ☐ Bleeding tendency
- ☐ Heart Arrhythmia ☐ Diabetes ☐ Congenital heart defect ☐ Glaucoma ☐ Stroke
- ☐ **Previous spine surgery, When**_____ **Type of Surgery/Level** _____
- ☐ **Ashtma, bronchities or emphysema** ☐ **Other illness/disease:** _____

2. Have you had any tests (MRI, CT, X-ray, etc.) performed for the symptoms you are currently experiencing or on the body part being scanned today? ☐ Yes ☐ No If yes, please list the date, type and where the test was performed:_____

_____

3. Have you had any surgeries or therapies (e.g., radiation therapy, chemotherapy, etc.)? ☐ Yes ☐ No
If yes, please list the date and type of surgery or therapy:_____

_____

4. Are you currently taking any medications? ☐ Yes ☐ No
If yes, please list all medications you are currently taking:_____

_____

5. Do you have any allergies (e.g., medication, latex, food, etc.)? ☐ Yes ☐ No
If yes, please list all allergies:_____

_____

PATIENT HISTORY QUESTIONNAIRE (MRI)

Please indicate if you have had any of the following:

1. Do you have a pacemaker, wires, defibrillator, or implanted heart valves? Yes ☐ No ☐
2. Have you ever had any brain surgery requiring aneurysm clips? Yes ☐ No ☐
3. Have you ever had a reaction to contract agent used for MRI, CT or X-ray? Yes ☐ No ☐
4. Do you have any surgical implanted material of any type in your body? Yes ☐ No ☐
5. Have you ever been exposed to metal fragment that could be in your eyes and/or body? Yes ☐ No ☐
6. Do you have a hearing aid, middle/inner ear prosthesis, stent or dentures? Yes ☐ No ☐
7. Do you have any type of electronic device (stimulator or pump) implanted to your body? Yes ☐ No ☐
8. Do you have any metal pin, joint, prosthesis or metallic object in, or attached to your body? Yes ☐ No ☐
9. Do you have or have you ever had tattoos, tattooed eyeliner of lipliner or body piercing? Yes ☐ No ☐
10. Do you wear a transdermal patch (nitroglycerin or nicotine)? Yes ☐ No ☐
11. Do you have a history of panic attacks of fear of enclosed or narrow places? Are you claustrophobic? Yes ☐ No ☐
12. Do you have a history of renal disease, seizure, asthma, emphysema? Yes ☐ No ☐
13. If you are a woman – are you pregnant, or is it possible that you might be pregnant? Yes ☐ No ☐
14. If you are a woman – are you breastfeeding? Yes ☐ No ☐
15. Is there any other item or device you believe we should know about prior to performing the procedure? Yes ☐ No ☐

    If yes, please describe: _____

I certify that I have read and understood the questions asked in this questionnaire and that the above responses are correct to the best of my knowledge. I understand that it is my responsibility to inform Prohealth Advanced Imaging Institute of any metal fragments and/or devices that may be in my body and that by failing to do so may cause serious bodily injury or be like threatening. I agree that should I have any metal in my body and, after consultation with a physician, elect to proceed with the MRY, U agree to release ProHealth Advanced Imaging Institute from any and all liability for any Injury.

ASSIGNMENT AND RELEASE:

I hereby authorize payment to be made directly to ProHealth Advanced Imaging Institute LLC, and fully understand that I am the responsible party for all medical bills incurred by me at the above mentioned facility. I also authorize the release of any information required for the processing of this claim. If a legal action to enforce payment, I agree to pay a reasonable attorney fee.

I hereby authorize ProHealth Advanced Imaging Institute to disclose when treated by the above named insurance carrier or its representatives, transmissions of portions of patient's medical records to Physicians Data Corporation for electronic storage and retrieval, any and all information with respect to any illness(es), or injury(ies), medical history of treatment and copies of all medical records, a photostatic copy of this authorization shall be considered effective and valid as the original.

PATIENT OR LEGAL REPRESENTATIVE SIGNATURE	PRINT NAME AND AUTHORITY (IF LEGAL REPRESENTATIVE)	DATE
WITNESS OR INTERPRETER SIGNATURE	PRINT NAME	DATE
PHYSICIAN/REGISTERED NURSE/TECHNOLOGIST	PRINT NAME AND TITLE	DATE

Technologist Notes: _____