Anaheim Hills Imaging Center

Clinical History for MRI Procedure

Name		Date of Birth	MRN:
Today's Date	Weight	Referring physician	

Previous Imaging

Previous Diagnostic Imaging Procedure(s): (**Related to TODAY'S VISIT ONLY**)

MRI ☐ No ☐ Yes, Where: ________________________ When: ________________

CT ☐ No ☐ Yes, Where: ________________________ When: ________________

Personal Medical History

History of Cancer ☐ No ☐ Yes, Type: ____

Radiation / Chemotherapy ☐ No ☐ In Progress ☐ Complete, When: _________________________

Reason for Today's Visit

Symptoms: ____

____

How long have you had these symptoms? ____

Extremity Pain ☐ No ☐ Yes, Weakness ☐ No ☐ Yes, Numbness/tingling ☐ Yes ☐ No

If yes, which side? ☐ Right ☐ Left

Have you had an injury? ☐ No ☐ Yes, Date of Injury: ___________________

Describe injury: ____

Previous Surgery (**Related to TODAY'S VISIT ONLY**) ☐ No ☐ Yes, Date of surgery: ___________________

Type of Surgery / Describe: ____

Your signature below indicates (1) that the information you have provided on this form is true and accurate; (2) that you have received all the information that you desire concerning the diagnostic imaging procedure; and (3) that you authorize and consent to the performance of the diagnostic imaging procedure.

____ _________________________________

Signature (patient/guardian) Date

If signed by other than patient, please indicate relationship ______________________________________

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Exam(s) Performed: ____ Previous available for comparison ☐

☐ **STAT Report Required**

☐ Arthrogram Injection: Performed by: ____________________________________

☐ IV Injection: Vial amount opened _________ ml Contrast: __________ cc Gad

☐ Right ☐ Left _____________ (location)

Injected by: ______________ Complications: ☐ No ☐ Yes

Tech Notes: ____ Technologist: ___________