



**Howard Open MRI Center**  
 6100 Day Long Lane, #107  
 Clarksville, MD 21029  
 PH: 410.531.1900 FX: 410.531.0484  
*Comfort and Peace of Mind.*

# Patient Screening and Clinical History Questionnaire

Patient Name	Date of Birth	Age	Gender
Referring Clinician	Phys. Telephone		

	Yes	No		Yes	No
Cardiac Pacemaker			Hearing Aid or Implant		
Brain or Aneurysm Clips or Surgery			Ever Worked as a Welder/Metal Worker		
Surgery to your head or heart			Ever had Metal Fragments Removed from Eye		
Implanted Insulin/Chemotherapy Pump			Removable Dental Work		
Joint Replacements or Prosthesis			Are you wearing a nicotine patch?		
Orbital Prosthesis (False Eye)			Body Piercing, Tattoo or Permanent Make-up		
Foreign metal or medical device inside your body			History of smoking		
Electronic or magnetic object in/on your body			<b>For women of childbearing years</b>		
Neurostimulators (TENS unit)			Any possibility of being pregnant		
Heart Disease			Do you have an IUD in place		
Peripheral Vascular Disease			When was you last menstrual period (start date)		
Is exam needed as a result of a Motor Vehicle Accident or Worker's Comp case?			Are you breastfeeding		

(1) **What problems, symptoms, and conditions are you experiencing that are resulting in this exam being ordered?**

(2) **What do you think might have caused the problem and *when* did the problem start?**

(3)  Yes  No **In addition to the doctor who referred you for today's scan, are there any other doctors who should receive a copy of your report?**

**Doctor's Name:** \_\_\_\_\_ **TEL:** \_\_\_\_\_ **FAX:** \_\_\_\_\_  
**Doctor's Name:** \_\_\_\_\_ **TEL:** \_\_\_\_\_ **FAX:** \_\_\_\_\_

Complete:	Yes	No
Headache		
Dizziness		
Fainting Spells		
Hypertension		
Asthma		
Stroke		
Multiple Sclerosis		
Blood Disorder		
Kidney or liver disease		
Are you diabetic?		

Complete for scans to your <b>brain, head or neck</b>	No	Right Side	Left Side
Face weakness/numbness			
Arm weakness/numbness			
Leg weakness/numbness			
Blurring or double vision			
Hearing loss			
ringing in ears			
Loss of coordination			
Mental awareness change	<input type="checkbox"/> No <input type="checkbox"/> Yes		

For exams to <b>lumbar or thoracic</b>	No	Right Side	Left Side
Pain to buttock			
Pain to leg			

For exams to <b>shoulder</b>	No	Right Side	Left Side
Pain to shoulder			
Pain to arm			

(4)  Yes  No **Have you had any previous *surgery* to the **PART OF YOUR BODY WE ARE SCANNING** today?**  
**Date**                      **Type of surgery**                      **At what facility**

(5)  Yes  No **Have you had any previous *surgery* to *any part* of your body not covered in question #4?**  
**Date**                      **Type of surgery**                      **Date**                      **Type of surgery**



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Patient Name \_\_\_\_\_

(6)  Yes  No **Have you had any previous *radiology exams* to the PART OF YOUR BODY WE ARE SCANNING today (for example: nuclear medicine, MRI, Bone Scan, CAT Scan, Ultrasound or X-ray)?**

<u>Date</u>	<u>Type of Exam</u>	<u>At What facility</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

(7)  Yes  No **Have you had any *injections* to the PART OF YOUR BODY WE ARE SCANNING today?**  
*If yes, please provide the type of injection(s) and date(s):* \_\_\_\_\_

(8)  Yes  No **Have you had any *physical therapy* for the PART OF YOUR BODY WE ARE SCANNING today?**  
*If yes, please provide the dates and number of sessions:* \_\_\_\_\_

(9)  Yes  No **Have you had any *biopsy* on the PART OF YOUR BODY WE ARE SCANNING today?**  
*If yes, please provide the dates and outcome:* \_\_\_\_\_

(10)  Yes  No **Have you had any history of cancer?** *If yes, please provide details on type of cancer and what action was taken (such as surgery, radiation therapy, chemotherapy).*

\_\_\_\_\_

\_\_\_\_\_

(11) **Please list all current medications:** \_\_\_\_\_

\_\_\_\_\_

(12) **Please list any food or drug allergies:** \_\_\_\_\_

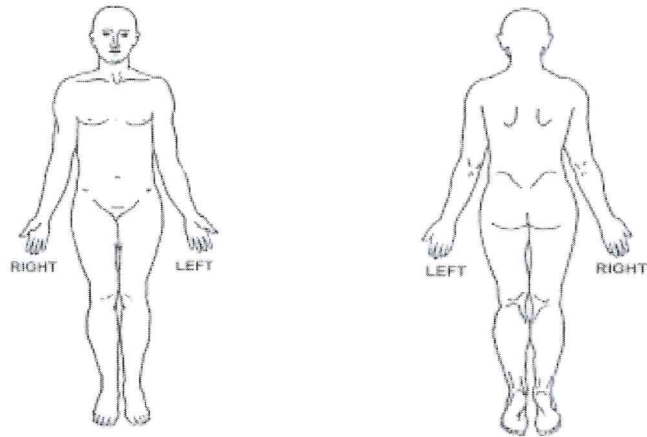
(13) **Please list any other medical problems or issues.** \_\_\_\_\_

\_\_\_\_\_

**(14) Pain/Symptom Description**

- Please circle the area of pain and/or discomfort on the drawing below.
- Draw arrows if the pain extends from one area to another.
- Please indicate the symptoms using a capital letter to describe the pain.

(Description of Pain: **D**=Dull Pain, **S**=Sharp Pain, **N**=Numbness, **T**=Tingling)



**Patient Signature:** \_\_\_\_\_ **Date** \_\_\_\_\_

Technologist Comments: