MRI Patient History

MBJ MR Imaging
2360 Mullan Rd., Suite C
Missoula, MT 59808
(406) 829-5567 Phone
(406) 532-8774 Fax

Patient Name: _____ DOB: ____/____/____ ❑ Male ❑ Female Height: _____Weight: _____lbs

Referring Provider: _____ Date of Exam: ___/____/____ Time of Exam: _____ AM PM

Exam Type: _____

When did the symptoms begin? _____

Is this a result of an injury? ❑ Yes ❑ No If yes, please explain injury? _____

_____

Location of pain: _____

_____

Dislocating, locking, catching, subluxing or giving out? _____

Swelling? ❑ Yes ❑ No If yes, where? _____

Popping or clicking? ❑ Yes ❑ No If yes, where? _____

Limited Range of motion? ❑ Yes ❑ No If yes, which motions? _____
_____

Have you had surgery on this body part? ❑ Yes ❑ No If yes, type and when?_____
Where? _____
Called for operative report? ❑ Yes Who performed your surgery? _____
_____

Have you had any imaging of this body part? ❑ Yes ❑ No If yes, when? _____
Where? _____
Pushed prior imaging? ❑ Yes Type? _____
_____

Have you had x-rays of this body part? ❑ Yes ❑ No If yes, when and where? _____
Pushed prior imaging? ❑ Yes
_____

History of Cancer? ❑ Yes ❑ No If yes, what type and when were you diagnosed? _____
_____

Do you have any cardiac issues? ❑ Yes ❑ No If yes, what? _____

Are you diabetic? ❑ Yes ❑ No If yes, what type and when were you diagnosed? _____

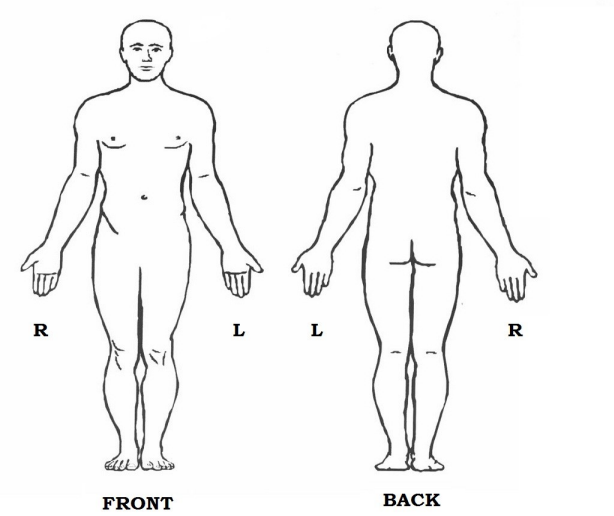
Please mark on the diagram the location of your pain:

Pain / ache: XXX

Numbness: - - -

Pins and needles: 0000

Please mark with a large **X** on the diagram where the pain is the *worst* now.



Rule Out:

6.6.17 KK