Gulf Coast
MRI & Diagnostic
www.gulfcoastmri.com

MRI History Sheet

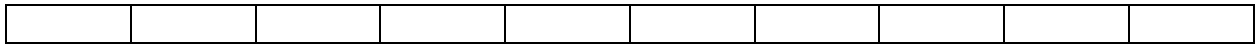
Date of Exam _____/_____/_____ Time of Exam _____ am/pm

Patient Name _____ D.O.B _____/_____/_____

Pain? **Y** **N** If yes, where? _____ Claustrophobic: _____YES _____ NO

When did the pain occur? _____ How did the pain occur? _____

Rate pain from 0 to 10 with 0 indicating no pain and 10 representing the worst possible pain



0 1 2 3 4 5 6 7 8 9 10

No pain — Moderate pain — Worst pain

Office Staff use only

HIGH FIELD MRI ◯ **OPEN MRI** ◯

Technologist _____ Exam _____ Referring Physician _____

Type and Quantity of IV contrast: _____ Injection Site: _____

Lot # _____ Exp. Date ____/____/_____ Time of Injection _____ am/pm

Oral/ IV Sedation _____ Amount given: _____ Creatnine _____eGFR _____

Previous Studies: ____Yes ___No **STAT Studies:** ____Yes ____No

Numbness/Tingling ___Yes ___No **Headaches:** ____Yes ____ No

Upper extremity ___RIGHT ___LEFT Lower extremity ___RIGHT ___LEFT

_____

_____

_____

_____

Physician Diagnosis _____

Limitation/ Notes _____

_____

_____