RADDICO
RADIOLOGY DIAGNOSTIC IMAGING CORPORATION

Medical Services Provided by Anthony G. Bledin, M.D., INC.

MRI Patient History

Patient Name	Date	Weight
Referring Physician	Referring Physician Phone	

List all surgeries related to the exam(s) you are having done today:

_____

_____

Have you had an MRI or x-ray on the area we are scanning today? ☐ Yes ☐ No
If yes, when?_____ **Where?**_____

Reason you are here today? Explain your medical problem in detail. (What is the problem? Where is the problem? Etc.) _____

_____

Is your problem related to an injury? ☐ Yes ☐ No **Date of injury?** _____

How were you injured? ☐ MVA ☐ Work ☐ Other_____

Have you taken and sedation today to relax you for this procedure?_____ ☐ Yes ☐ No
If yes, what? _____**Do you have someone to drive you home?** ☐ Yes ☐ No

Do you have a history of cancer or tumors? ☐ Yes ☐ No **If yes, where?**_____
When?_____ **Radiation therapy/Chemo Therapy?**_____

Please check any of the following symptoms you are experiencing:

☐ Headaches	☐ Nausea	☐ Blackouts	☐ Dizziness
☐ Seizures	☐ Memory Loss	☐ Hearing Loss	☐ Ringing in Ears
☐ Blurred Vision	☐ Abdominal Pain	☐ Chest Pain	☐ Unexpected Weight Loss
☐ Back Pain	☐ Neck Pain	☐ Leg Pain (Right/Left)	☐ Arm Pain (Right/Left)

☐ **Numbness? Explain**_____ ☐ **Weakness? Explain**_____

Patient signature:_____**Date:**_____

Revised 4-4-2011