



MRI EXAM QUESTIONNAIRE

Patient Name: _____

Your exam, (images and report), will automatically be sent to your Oregon Clinic Doctor

Please provide the name of your current Primary Care Physician _____

Would like today's Exam Report sent to another doctor? YES NO

If yes, please provide the physicians name and address:

Name: _____

Address: _____

Any personal history of cancer? YES NO

If yes, when were you diagnosed, where was it located, and what were the treatments?

DATE	LOCATION	TREATMENTS
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you had a prior testing on the area being scanned today? YES NO

DATE	WHERE WAS IT DONE	WHAT KIND (CT,MR, Myelogram, etc.)
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever had any surgery in that same area? YES NO

DATE	SURGERY SITE	REASON
_____	_____	_____
_____	_____	_____
_____	_____	_____

TO BE COMPLETED BY THE OREGON CLINIC STAFF

Reason for scan? _____

Tech notes _____

IV contrast _____ ML of _____ Tech's initials _____

