BERMUDA HEALTHCARE SERVICES

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MRI SYMPTOMS SUMMARY

Date: DD / MM / YY

Patient Name: _____ Date of Birth: DD / MM / YY Weight: _____ Height: _____

***Please check the circle that applies or describe the symptoms that you are currently having or that prompted your physician to order this exam.**

Follow up for: _____

Pain? Where: _____

Numbness? Where: _____

Tingling? Where: _____

Weakness? Where: _____

Other Symptoms? Describe: _____

_____

How long have you had these symptoms? _____

Are they a result of an injury/accident? ◯**YES** ◯**NO** When? _____

If yes, describe: _____

Have you ever had surgery to this area? ◯**YES** ◯**NO** When? _____

If yes, describe: _____

If you have had spinal surgery please check the box for the area of your spine where the surgery was performed:

☐ NECK ☐ MID-BACK ☐ LOW BACK

Have you ever been diagnosed with cancer? ◯**YES** ◯**NO** When? _____

If yes, what part of the body? _____

Did you receive radiation or chemotherapy? ◯**YES** ◯**NO** When? _____

Have you had a previous MRI on this body part? ◯**YES** ◯**NO** When? _____

If yes, was it done at Lahey Clinic of another facility? _____

Have you received an infusion of Feraheme (ferumoxytol) within the past 90 days ◯**YES** ◯**NO**

PLEASE CHECK THE BOXES THAT APPLY FOR SYMPTOMS

Brain / Spine Symptoms: ☐ Nausea/Vomiting ☐ Seizures ☐ Dizziness ☐ Memory Loss ☐ Double Vision ☐ Decreased Vision ☐ Imbalance - Headache

Decreased Hearing ☐ RT ☐ LT

Ringing Ears ☐ RT ☐ LT

Joint / Bone Symptoms: ☐ Swelling Clicking ☐ Limited Motion ☐ Locking ☐ Giving Way

Mass / Lump

Chest / Abdomen / Pelvis: ☐ Nausea / Vomiting ☐ Mass / Nodule ☐ Weight Loss ☐ Weight Gain ☐ Shortness of breath

* In our effort to improve the quality and efficiency of our MRI Studies, the Department of Radiology is continuously testing and evaluating newer ways to improve the use of our MRI machines. Your examination may contain new approaches, which may potentially shorten or add a few minutes to the total time of your MRI.