McLaren Flint
FLINT, MICHIGAN 48532

McLaren MRI
PATIENT HISTORY

Please fill out all information below:

Patient Name: _____ DOB: ___/___/___

Exam: _____ DOS: ___/___/___

Diagnosis: _____

Current symptoms, signs, locations: _____

_____

☐ Non-Traumatic? Date of onset? _____

☐ Traumatic? Date of Injury? _____

Type of Injury: ☐ MVA ☐ Sports ☐ Lifting ☐ Fall ☐ Other_____

Intensity: ☐ Progressively Improving ☐ Progressively Worsening ☐ No Change

Medications/Injections:_____

Physical Therapy: ☐ No ☐ Yes ☐ Beneficial ☐ Non beneficial

Surgery on area being scanned & dates: _____

_____

Previous Exams (MRI, CT, US, X-RAY, NM) on area being scanned (when and where)

_____

History of cancer: (type and when diagnosed): _____

Patient Signature:_____

McLaren Staff Signature: _____Time:_____ Date: _____

Amount of contrast: _____ml

Creatinine: _____ GFR: _____ Date: _____