Northwestern Memorial® Hospital

Name: _____

Date of Birth: _____

Please answer these questions regarding your medical history

	Yes	No	N/A
Are you pregnant?			
Have you had a hysterectomy?			
Are you trying to get pregnant or is there a chance you may be pregnant?			
Date of last menstrual period / / or N/A			

Why are you having this MRI? Please list any symptoms that brought you to have this scan. (Example: headaches, seizures, pain.)

_____

_____

Have you ever had cancer? Yes No Do you have cancer? Yes No If yes, what kind and did it spread to other areas?

_____

_____

Have you ever had an injury in the area being scanned? Yes No If yes, what happened and when?

_____

_____

Have you ever had surgery in the area being scanned? Yes No If yes, what type and when?

_____

_____

Do you have any other medical conditions that we should know about, such as high blood pressure, or diabetes?

_____

_____

_____

Please indicate on the diagram below the side of your body where you are experiencing symptoms.