BrightWay Imaging MRI CLINICAL INFORMATION QUESTIONNAIRE

PATIENT NAME: _____ TODAY'S DATE _____

What problems brought you to the doctor that resulted in this exam being ordered? _____

_____

_____

What do you think might have caused the problem and when did the problem start? _____

_____

Have you had any prior surgery on the part of the body that we are scanning today? ☐ YES ☐ NO

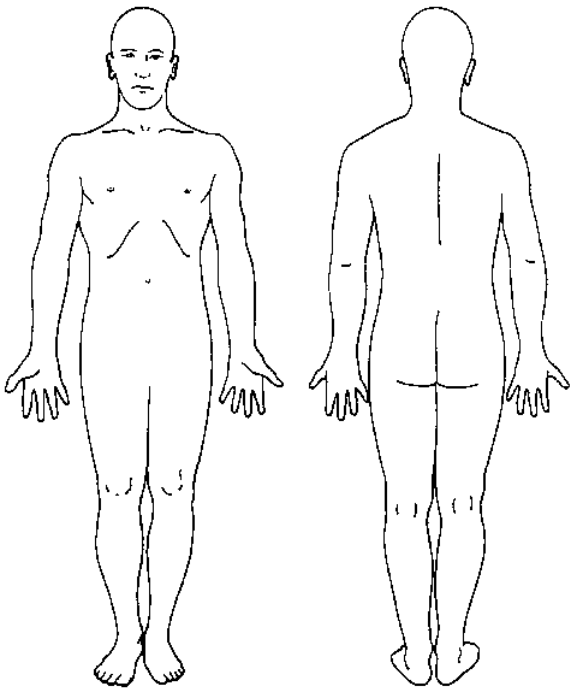
Please list type(s) of surgery and date(s):

DATE	TYPE OF SURGERY
_____	_____
_____	_____
_____	_____

If you have had any other TREATMENTS (including radiation or chemotherapy) involving the part of your body that we are examining today, please list them. _____

_____

Please circle area of pain and/or discomfort on the drawing below to the left. Draw arrows if pain extends from one area to another. Please indicate SYMPTOMS using the capital letters below.



FRONT BACK

RIGHT LEFT LEFT RIGHT

D = DULL ACHE
S = SHARP PAIN
N = NUMBNESS
T = TINGLING

Please answer the following:	**YES**	**NO**
Current or past history of Cancer	□	□
Diabetes	□	□
History of being medicated with Steroids or prednisone	□	□
High Blood Pressure	□	□
Kidney Problems	□	□