RIVER OAKS
MRI & DIAGNOSTIC

River Oaks MRI and Diagnostic

Diagnostic Imaging(X-Ray) Patient History Form

MRN: _________________________ Accession #: ___________________

Print Patient Name:	
DOB:	Age:
Referring Physician:	
Primary Care Physician:	

Pregnancy Release

To the best of your knowledge are you pregnant? _____Yes _____No

Date of Last Menstrual Cycle ____________

Hysterectomy _____Yes _____No Tubal Ligation _____Yes _____No

I am aware that having an X-ray or CT exam while pregnant could be harmful to an unborn baby. It is my understanding that protective shielding will be used when applicable and hereby give my consent to perform the X-Ray / CT Scan which my physician has prescribed

Patient/Guardian signature: ____

To help us perform the best exam for you, please answer the following questions

Age:	Height/ Weight:

What symptoms do you have relating to today's exam and when did they start?

____
____
____
____
____
____

List any surgeries you have had relating to today's exam (Date-type of surgery)

____
____
____
____

Is your problem related to an injury, trauma, or auto accident? ____Yes ____ No

If yes, date of injury? _______________

Please describe how you were injured:

____
____
____
____
____

Patient/Guardian signature____

Date: ____________