



MRI
CLINICAL QUESTIONNAIRE

NAME: _____ DATE: _____

ALLERGIES: _____

1. Why has your doctor sent you for this test? Did he/she give you a specific diagnosis?

2. Please describe what specific complaints/symptoms have been most bothersome to you?

3. How long have you had these complaints/symptoms? _____

4. Do you have a history of cancer? If so, what tyoe? _____

5. These complaints/symptoms have:

improved remained the same worsened

6. Have you had any previous surgery? yes no

If yes, type and date: _____

7. Have you had any previous testing done for this problem? yes no

If yes, please list all tests done:

