

Physicians MRI, LLP

Caritas Medical Arts Building
2625 Harlem Road, Suite 110
Cheektowaga, New York 14225

Name _____ Date _____

What symptoms have you been experiencing related to your exam today?

How long have you had this problem? _____

If you are experiencing pain, where is the pain located? _____

Does the pain radiate to another location? _____

Do you have any numbness and where _____

Do you have any weakness and where? _____

Have you had another diagnostic examination of the affected area? (circle below)

XRAY CT/CAT SCAN MRI

When and where? _____

Was there a recent accident or injury involving the area to be scanned? _____

If yes, approximate date _____

Have you had surgery on the affected area? _____

If yes, when and what was done? _____

Do you have any other medical conditions? _____

Have you had any radiation or chemotherapy treatment? _____

Women only: what was the date of your last menstrual period? _____

_____ _____
patient signature date