Imaging
AUGUSTA UNIVERSITY HEALTH

MRI/CT Examination Questionnaire

PATIENT INFORMATION

Last Name	First Name/Middle Initial	Date of Birth (MM/DD/YYYY)
		/ /

PERSONAL INFORMATION

HAVE YOU BEEN FULLY VACCINATED FOR COVID-19? ☐Yes ☐No IF SO, WHEN AND WHICH ARM?

_____

WHY ARE YOU HAVING THIS SCAN TODAY & WHAT SYMPTOMS ARE YOU EXPERIENCING?

_____

_____

WERE YOU INJURED? ☐Yes ☐No IF SO, EXPLAIN & GIVE THE DATE:

_____

_____

HAVE YOU HAD PRIOR SURGERY TO THIS AREA? ☐Yes ☐No IF SO, DESCRIBE & GIVE THE DATE:

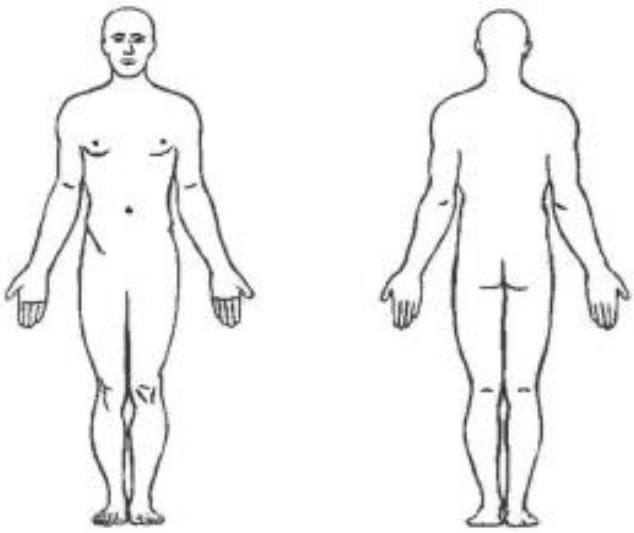
_____

_____

SYMPTOMS

PLEASE INDICATE AREAS OF SYMPTOMS BY:

P = PAIN
T = TINGLING
N = NUMBNESS
W = WEAKNESS



ACKNOWLEDGMENT

I attest that the above information is correct and true to the best of my knowledge.

_____
PATIENT / GUARDIAN NAME (PLEASE PRINT)

_____ _____
PATIENT / GUARDIAN NAME SIGNATURE DATE