



BAYSIDE STANDING MRI

130 Male Street, Brighton, VIC, 3186

Ph: (03) 9592 3319

Fax: (03) 9593 1876

Email: info@baysidestandingmri.com.au

www.baysidestandingmri.com.au

CONFIDENTIAL QUESTIONNAIRE

Your Details

CONFIDENTIAL – YOUR INFORMATION IS USED ONLY BY US AND RADIOLOGIST TO HELP GET THE BEST MRI RESULTS

NAME: _____

ADDRESS: _____

POSTCODE: _____

WORK PHONE: _____ HOME PHONE: _____

MOBILE PHONE: _____ EMAIL: _____

BIRTHDATE: _____ OCCUPATION: _____

HEIGHT : _____ WEIGHT: _____

IN CASE OF EMERGENCY CONTACT: _____ PHONE: _____

Who is your usual medical doctor (GP)? _____ Suburb/Town _____

How did you find out about our services? _____

Have you ever had an MRI scan before?

Yes ☐ When & why? _____

No ☐

Safety Check

Please tick, if you have any of the following (If you are unsure, do not hesitate to ask)

☐ Cochlear implant or Neurostimulator

☐ Pacemaker or Defibrillator

☐ An inserted pump device

☐ Any tattoos

☐ A programmable, magnetically adjustable ventriculoperitoneal shunt

☐ Any Piercings

☐ Had surgery in the past 6 weeks

If you checked any of the above, please elaborate: _____



BAYSIDE STANDING MRI

130 Male Street, Brighton, VIC, 3186

Ph: (03) 9592 3319

Fax: (03) 9593 1876

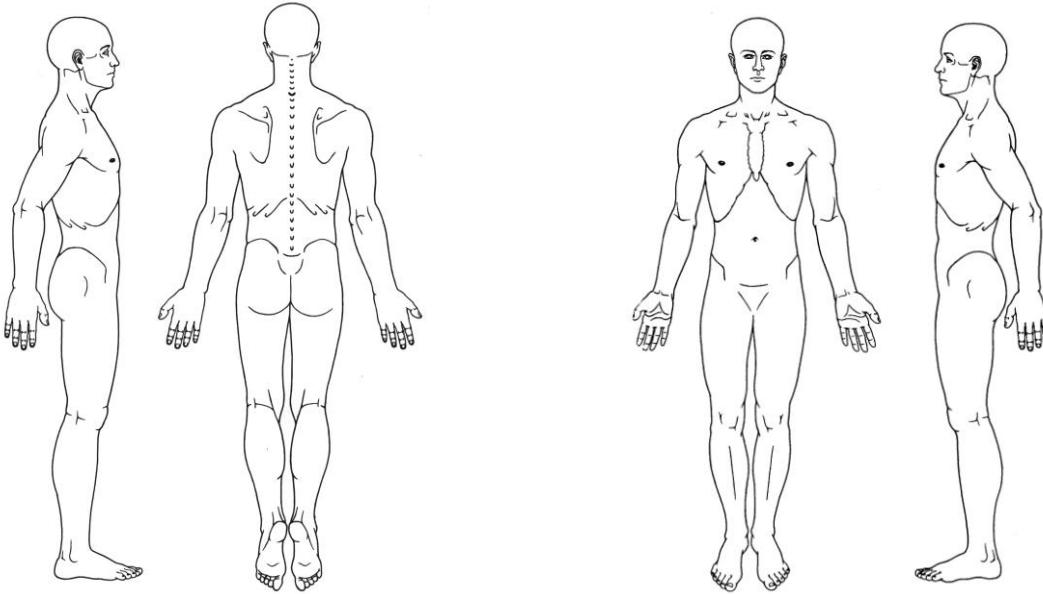
Email: info@baysidestandingmri.com.au

www.baysidestandingmri.com.au

CONFIDENTIAL QUESTIONNAIRE

Where is the Problem?

Please click/mark on the diagrams below any areas of discomfort or concern.



Financial

I understand that this office does not hold accounts. In the event that there is an unpaid account, I will be liable for any administration costs charged to me. I agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

Your Name: _____ Your signature: _____ Date: _____



BAYSIDE STANDING MRI

130 Male Street, Brighton, VIC, 3186

Ph: (03) 9592 3319

Fax: (03) 9593 1876

Email: info@baysidestandingmri.com.au

www.baysidestandingmri.com.au

CONFIDENTIAL QUESTIONNAIRE

Your Particular Health Problem

Please let us know the reason that an MRI is being requested.

Describe your *main* problem or symptoms: _____

When and how did it start? (date started or approximate duration) _____

Was there any of the following prior to or during the onset? (please circle)

- Illness / infection
- Trauma
- Other significant event

Is your problem? (please tick) getting worse ☐ not changing ☐ improving ☐

Is the pain? (please tick) Constantly there ☐ Intermittent - on and off ☐

What makes your symptoms worse? _____

What relieves your symptoms? _____

Are your symptoms worse at night or any specific time of the day? _____

Do you get pain traveling down into your arms or legs? Yes / No If yes, please describe _____

Does your current problem involve any of the following? If yes, where?

Tingling in either arm or leg Yes / No _____

Numbness in either arm or leg Yes / No _____

Weakness in either arm or leg Yes / No _____

'Weird' sensations in either arm or leg Yes / No _____

Have you seen anyone else for this current condition? (If yes, please list their names) Yes / No _____

Have you ever had this problem before? Yes / No If yes, please describe, including how often _____

Are you currently taking *any* medication, substances, vitamins, supplements, herbs? Yes / No

Please list all: Name Reason

Your Name: _____ Your signature: _____ Date: _____

THANK YOU for taking the time to complete this important questionnaire to help us help you.

Please send the completed form back to us. You may do so via email to info@baysidestandingmri.com.au or via fax to (03) 9593 1876