Facility Name: _____

Address: _____

City, State ZIP: _____

# Oncology MRI Patient History

Effective Date: June 1, 2018

## Patient Demographics

Patient Name: _____ Medical Record #: _____

## Cancer History

☐ Yes ☐ No Do you or have you ever had cancer? Primary Type of Cancer: _____

☐ Yes ☐ No Biopsy? Region: _____ Results: _____

☐ Yes ☐ No Treated?

☐ Yes ☐ No Surgery? What Kind? _____ Date: _____

☐ Yes ☐ No Radiation? Body Part: _____ Date: _____

☐ Yes ☐ No Chemotherapy? Name of Drug(s): _____

Initial Date: _____ Date Last Administered: _____

☐ Yes ☐ No Immunotherapy? Name of Drug(s): _____

Initial Date: _____ Date Last Administered: _____

☐ Yes ☐ No Second Type of Cancer? _____

☐ Yes ☐ No Biopsy? Region: _____ Results: _____

☐ Yes ☐ No Treated?

☐ Yes ☐ No Surgery? What Kind? _____ Date: _____

☐ Yes ☐ No Radiation? Body Part: _____ Date: _____

☐ Yes ☐ No Chemotherapy? Name of Drug(s): _____

Initial Date: _____ Date Last Administered: _____

☐ Yes ☐ No Immunotherapy? Name of Drug(s): _____

Initial Date: _____ Date Last Administered: _____

Please list all other cancers you may have had: _____

## Prior Imaging Studies

Date of Most Recent CT Exam: _____ at: _____

Body Part Scanned: _____

Date of Most Recent PET/CT Exam: _____ at: _____

Body Part Scanned: _____

Date of Most Recent MRI Exam: _____ at: _____

Body Part Scanned: _____

## Verification

Technologist Signature: _____ Date: _____