

Pocono MRI Imaging and Diagnostic Center
Priors Questionnaire

PATIENT NAME _____ DATE: _____

Body Part To Be Tested Today: _____

**Have you had prior MRI, CT, Ultrasound, Nuclear Medicine or X-Ray
of this body part? NO YES**

If Yes please indicate the date, type and where it was performed:

	PART OF BODY	DATE	FACILITY
MRI	_____	_____	_____
	_____	_____	_____
Cat Scan	_____	_____	_____
	_____	_____	_____
Ultrasound	_____	_____	_____
	_____	_____	_____
Nuclear Medicine	_____	_____	_____
	_____	_____	_____
X-Ray	_____	_____	_____
	_____	_____	_____

Prior exams and reports of the same body part are necessary to compare to today's exam. If you have these studies, please give them to the technologist or front desk staff. If you have NOT brought them with you, it will be necessary for you to obtain them. If we can be of any assistance to you in obtaining these prior exams; please ask for an authorization form so that we may send for the studies immediately as not to delay today's results.