NEW MYOSTRAIN PATIENT CLINICAL HISTORY FORM

To fill out this form manually, see last page

General Patient Information

Full Name: _____ Date: _____

Phone: _____ Email: _____

Address: _____ City: _____

State: _____ ZIP: _____

Medical Contact Information

Doctor Name: _____ Doctor Specialty: _____

Doctor Phone: _____

Insurance Information

Insurance Name: _____ Phone: _____

Group No.: _____ Member ID: _____

Patient History—Demographics

Sex: ☐ M ☐ F	Age: _____
Height: _____ ☐ cm ☐ in	Weight: _____ ☐ kg ☐ lb
Smoker? ☐ Never ☐ Current ☐ Former	Drinks? ☐ Never ☐ Occasionally ☐ Often

MRI SCREENING QUESTIONS

Are you claustrophobic? ☐ Yes ☐ No	
Have you had prior surgery or an operation of any kind? ☐ Yes ☐ No	If yes, please indicate date and type of surgery:
Have you had an injury to the eye involving a metallic object (e.g. metallic slivers, foreign body)? ☐ Yes ☐ No	If yes, please describe:
Have you ever been injured by a metallic object or foreign body (e.g. BB, bullet, shrapnel, etc.)? ☐ Yes ☐ No	If yes, please describe:
Are you pregnant or suspect that you are pregnant? ☐ Yes ☐ No	

Please indicate if you have any of the following (check all that apply):	
☐ Aneurysm clip(s)	☐ Insulin or infusion pump
☐ Cardiac pacemaker	☐ Implanted drug infusion device
☐ Implanted cardioverter defibrillator (ICD)	☐ Any type of prosthetic or implant
☐ Electronic implant or device	☐ Artificial or prosthetic limb
☐ Magnetically activated implant	☐ Any metallic fragment or foreign body
☐ Neurostimulation system	☐ Any external or internal metallic object
☐ Spinal cord stimulator	☐ Hearing aid *(Remove before entering the MR system)*
☐ Cochlear implant or implanted hearing aid	

SYMPTOMS & FAMILY HISTORY

Patient History—Symptoms

Are you experiencing any of the following symptoms?
☐ Chest pain, tightness, pressure, or discomfort
☐ Weakness or fatigue
☐ Shortness of breath
☐ Lightheadedness or dizziness
☐ Pain, numbness, weakness, or coldness in your legs or arms
☐ Pain in neck, jaw, throat, upper abdomen, or back
☐ Other: _____
☐ None

Patient Family History

☐ **No significant family history is known**

CHECK ALL THAT APPLY ✓	Heart Disease	Diabetes	Hypertension	Heart attack	Stroke	Atrial Fibrillation	Kidney Disease	Other: ____	Other: ____	Other: ____
Mother	☐	☐	☐	☐	☐	☐	☐			
Father	☐	☐	☐	☐	☐	☐	☐			
Brother	☐	☐	☐	☐	☐	☐	☐			
Sister	☐	☐	☐	☐	☐	☐	☐			
Child	☐	☐	☐	☐	☐	☐	☐			
Maternal Grandmother	☐	☐	☐	☐	☐	☐	☐			
Maternal Grandfather	☐	☐	☐	☐	☐	☐	☐			
Paternal Grandmother	☐	☐	☐	☐	☐	☐	☐			
Paternal Grandfather	☐	☐	☐	☐	☐	☐	☐			
Other: _____	☐	☐	☐	☐	☐	☐	☐			

CARDIAC HISTORY

Patient History—Cardiac Diagnosis ☐ No cardiac diagnosis is known

Do you have any of the following diagnoses? (checklist)	
☐ AIDS ☐ HIV	☐ hypercholesterolemia
☐ amyloidosis: AL ☐ / ATTR ☐	☐ hypertrophic cardiomyopathy
☐ aortic aneurysm: location(s) _____	☐ implantable devices: Pacemaker ☐/ICD ☐/CRT ☐
☐ aortic valve disease, stenosis ☐ /regurgitation ☐	☐ left bundle branch block
☐ arterial hypertension	☐ left ventricular non-compaction cardiomyopathy
☐ atrial arrhythmias: AF ☐ /atrial flutter ☐ /other ☐	☐ liver disease: mild ☐ /moderate or severe ☐
☐ atrioventricular block	☐ malignant lymphoma
☐ cancer: *if yes, complete cancer history form*	☐ mitral valve disease: moderate ☐ / severe ☐
☐ cardiomyopathy: ischemic ☐ /non-ischemic ☐	☐ myocardial infarction
☐ cerebrovascular disease	☐ myocarditis / ☐ pericarditis
☐ chronic pulmonary disease (e.g. COPID)	☐ peripheral vascular disease
☐ connective tissue disease	☐ pulmonary hypertension
☐ coronary artery disease: LAD ☐ / RCA ☐/ CX ☐	☐ renal disease: mild ☐/moderate ☐ /severe ☐
☐ congestive heart failure (CHF)	☐ right bundle branch block
☐ COVID-19	☐ tricuspid valve disease: moderate / severe
☐ dementia	☐ sarcoidosis: cardiac involvement—no ☐ /yes ☐
☐ diabetes—end organ damage: no ☐ /yes ☐	☐ ulcer disease
☐ hemiplegia	☐ ventricular tachycardia/fibrillation

Patient History—Cardiac Medication ☐ No cardiac medication history is known

MEDICATIONS *(Please list ALL)*	**DOSE** *(Mg., pill, etc.)*	**TIMES PER DAY**

CANCER HISTORY

Patient History—Cancer History

☐ **No history of cancer is known**

Do you have a history of cancer? (Check all that apply)	
☐ Bladder	☐ Melanoma
☐ Breast	☐ Multiple Myeloma
☐ Carcinoma	☐ Acute Myeloid Leukemia
☐ Colorectal	☐ Ovarian
☐ Esophageal	☐ Pancreatic
☐ Hodgkin's	☐ Prostate
☐ Non-Hodgkin's Lymphoma	☐ Sarcoma
☐ Kidney	☐ Skin
☐ Liver	☐ Stomach
☐ Lung	☐ Other
☐ Metastasis (specify):	

Patient History—Chemotherapy History

☐ **No history of chemotherapy is known**

CHEMOTHERAPY TYPE *(Please list ALL)*	**DOSE** *(Please list cumulative dosages)*	**FREQUENCY OF THERAPY**

IF YOU WISH TO FILL OUT THIS FORM MANUALLY:

1. Print off all pages
2. Fill out form
3. Mail, email, or fax completed form to either of the locations below

MEMORIAL MRI & DIAGNOSTIC
1346 Campbell Road
Houston, Texas 77055
Email: myostrain@memorialdiagnostic.com
Fax #: 713-461-1969

MEMORIAL MRI & DIAGNOSTIC
1241 Campbell Road
Houston, Texas 77055
Email: myostrain@memorialdiagnostic.com
Fax #: 713-461-1969

If you have any further questions, please call 713-461-3399.