

MRI PATIENT DATA SHEET

NAME: _____ APPT. DATE: _____

PLEASE ANSWER (YES) OR (NO) TO THE FOLLOWING:

- | | | | | |
|-------------------|--|-------|-------------------------|--|
| METAL IMPLANTS | <input type="checkbox"/> YES <input type="checkbox"/> NO | _____ | NEUROSTIMULATOR | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| METAL PINS/SCREWS | <input type="checkbox"/> YES <input type="checkbox"/> NO | _____ | METAL JOINT REPLACEMENT | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| PACEMAKER | <input type="checkbox"/> YES <input type="checkbox"/> NO | | ANEURYSM CLIPS | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| PREGNANT | <input type="checkbox"/> YES <input type="checkbox"/> NO | | BRAIN SURGERY | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| HEART SURGERY | <input type="checkbox"/> YES <input type="checkbox"/> NO | | ARTIFICIAL HEART VALVE | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| HARRINGTON ROD | <input type="checkbox"/> YES <input type="checkbox"/> NO | | DENTURES | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| EAR IMPLANTS | <input type="checkbox"/> YES <input type="checkbox"/> NO | | HEARING AID | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| INFUSION PUMP | <input type="checkbox"/> YES <input type="checkbox"/> NO | | SHRAPNEL/BULLETS/SHOT | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| TENS UNIT | <input type="checkbox"/> YES <input type="checkbox"/> NO | | SHUNT/STENT | <input type="checkbox"/> YES <input type="checkbox"/> NO |

- CURRENT WEIGHT:** _____ EMPLOYED AS A METAL WORKER? YES NO
METAL FRAG/SPLINTER IN: EYES YES NO
LUNGS YES NO

REGARDING THE BODY PART YOU ARE HAVING SCANNED TODAY:

- PREVIOUS X-RAYS YES NO WHERE? _____ WHEN _____
PREVIOUS CAT SCAN YES NO WHERE? _____ WHEN _____
PREVIOUS MRI YES NO WHERE? _____ WHEN _____

PATIENT/PARENT AUTHORIZATION

- I **DO NOT** HAVE A PACEMAKER OR DEFIBULATOR.
- I **DO NOT** HAVE METAL IN MY BODY.
- I **DO** HAVE THE FOLLOWING METAL IN MY BODY: _____
- I AUTHORIZE AN INJECTION OF A PARAMAGNETIC MATERIAL UTILIZED TO BETTER VISUALIZE THE STRUCTURE OF THE SCAN(S).

INFORM THE STAFF IF YOU ARE:

- | | |
|---|--|
| PREGNANT OR BREASTFEEDING | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| HAVE ANEMIA OR ANY DISEASE THAT AFFECTS RED BLOOD CELLS | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| HISTORY OF ASTHMA, CHRONIC BRONCHITIS OR EMPHYSEMA | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| ARE YOU CURRENTLY ON RENAL DIALYSIS | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| HISTORY OF KIDNEY FAILURE | <input type="checkbox"/> YES <input type="checkbox"/> NO |

I HAVE CAREFULLY REVIEWED AND ANSWERED THE ABOVE TO THE BEST OF MY KNOWLEDGE:

SIGNATURE OF PATIENT/PARENT _____ DATE _____ WITNESS _____

MRI CLINICAL INFORMATION QUESTIONNAIRE

PATIENT NAME: _____ TODAY'S DATE: _____

What problems brought you to the doctor that resulted in this exam being ordered? _____

What do you think might have caused the problem and when did the problem start? _____

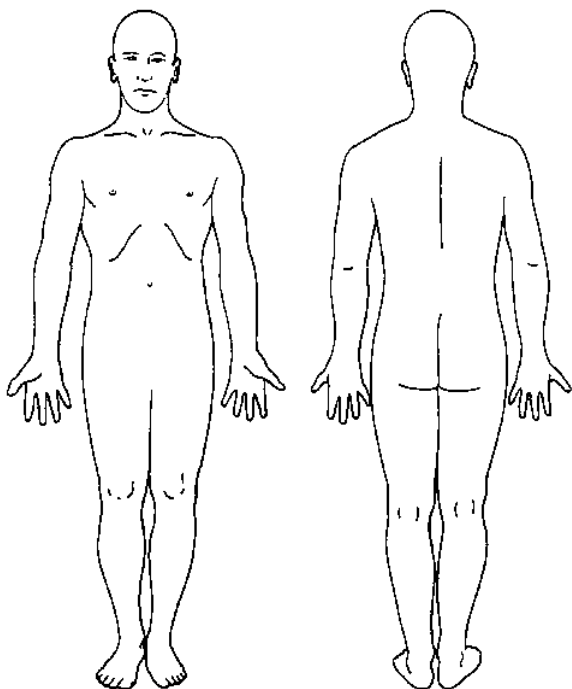
Have you had any prior surgery on the part of the body that we are scanning today? YES NO

If **YES**, please list type(s) of surgery and date(s):

<u>DATE</u>	<u>TYPE OF SURGERY</u>
_____	_____
_____	_____
_____	_____

If you have had any other TREATMENTS (including radiation or chemotherapy) involving the part of your body that we are examining today, please list them: _____

Please circle the area of pain and/or discomfort on the drawing below to the left. Draw arrows if pain extends from one area to another. Please indicate SYMPTOMS using the capital letters below.



FRONT

BACK

RIGHT LEFT

LEFT RIGHT

D = DULL ACHE
S = SHARP PAIN
N = NUMBNESS
T = TINGLING

Please answer the following:	YES	NO
Current or past history of Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
History of being medicated with Steroids or prednisone	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>