MRI SPINE
PATIENT HISTORY AND SCREENING

Name: _____ Referring Physician: _____

Please explain your present complaint or problem in detail _____

_____

How long have you had this problem? _____

Is this problem as a result of injury? _____

My problem affects my: Left arm Left leg Left side
(Please circle any/all
extremities involved) Right arm Right leg Right side

Please check if you have any of the following and where:

Weakness _____ Numbness _____
Pain _____ Cancer _____
Radiation _____ Steroid injections _____

Have you experienced: Bowel Changes? ❑ Yes ❑ No Bladder Changes? ❑ Yes ❑ No
Fever? ❑ Yes ❑ No
Have you had previous spine surgery? ❑ Yes ❑ No If so, explain _____

_____

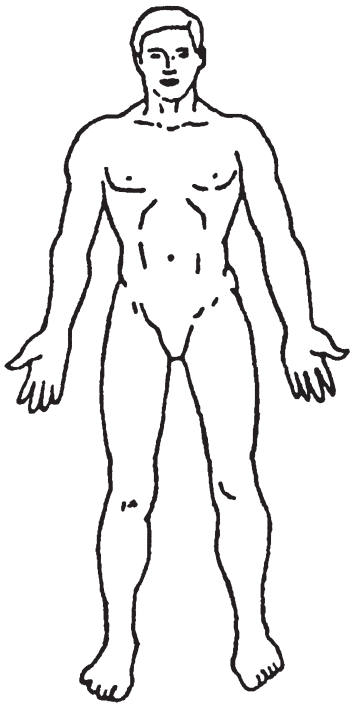
Have you had any previous studies of the body part being scanned today? ❑ Yes ❑ No

If yes, type of study? _____
Where and when? _____

On the drawings below, please circle/shade the areas of your pain and other symptoms:

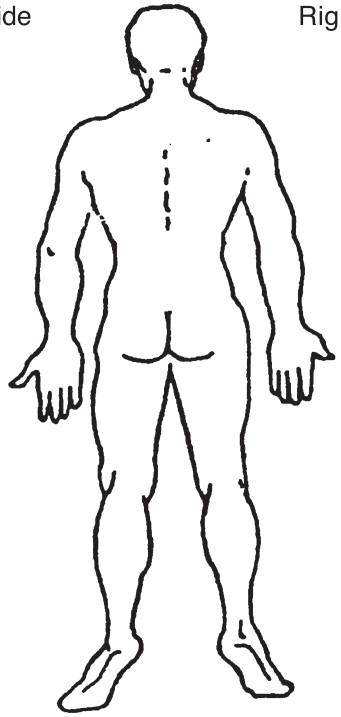
FRONT

Right Side Left Side



BACK

Left Side Right Side



(please turn over)

PATIENT MRI SAFETY SCREENING FORM

Name_____ Weight_____

Date of Birth_____ Last menstrual period_____ ❑ N/A

Please check any that apply:
Possibly pregnant? ❑ Yes Claustrophobic (afraid of closed in areas)? ❑ Yes
Have you **EVER** worked around metal grinding/filing or welding? ❑ Yes
Have you **EVER** had metal particles in your eyes? ❑ Yes

Please list any surgeries you have had _____

_____

Please list any known allergies to latex, tape or drugs that you have: _____

Do you have history of renal disease or dialysis? ❑ No ❑ Yes

The following items ***can*** interfere with MR imaging and ***can*** be hazardous to your safety. Please check appropriate items & notify the Technologist if you have any of the following:

_____Cardiac pacemaker	_____Hearing aids	_____Brain clips
_____Cochlear implants	_____Aortic clips	_____Shunts
_____Carotid clips	_____Joint replacements	_____Neurostimulators (Tens)
_____Harrington rod	_____Heart valve replacements	_____Bone or joint pins
_____Insulin pump	_____Prosthesis	_____Electrodes
_____Wire sutures	_____Metal mesh	_____Shrapnel
_____Metal plates	_____Dental/teeth work with magnets	_____Stents
	_____Therapeutic Magnets or screws, nails or metal rods	

_____Other (please list) _____

DO NOT ENTER THE SCANNING ROOM WITH ANY OF THE FOLLOWING ITEMS:
Hearing aids, Magnetic strip cards (credit cards, bank cards), Jewelry, Hairpins/barrettes, Glasses, Watch, Wallet/Money Clip, Pocketknife, Safety pins, Pens/pencils, Phone/pager, Keys, Coins

**** Lockers will be provided to lock patient valuables ****

I have reviewed and confirmed that the above information is complete to the best of my knowledge:

Pt. Signature_____ **Date**_____

Please turn form over for additional information

MRI Technologist has interviewed patient:_____Tech