MRI PATIENT HISTORY

DMOS ORTHOPAEDIC CENTERS

Patient's Name: _____ Today's Date _____

Date of Birth: _____ Height: _____ Weight: _____

List ALL previous surgeries you have had: _____

_____

_____

Yes ❑ No ❑ **Have any of these surgeries been in the last 6 weeks?

Indicate *Yes* or *No* for the following listed devices and questions.

Yes ❑ No ❑	**Pacemaker or Cardioverter defibrillators, Retained Cardiac Pacing Wires or Temporary Cardiac Pacing Wires**
Yes ❑ No ❑	**Do you have any electronic devices in you or attached to your body (ie: Insuline pump, stimulators, monitors)**
Yes ❑ No ❑	Are you Pregnant?
Yes ❑ No ❑	Heart Valve
Yes ❑ No ❑	Carotid Artery Vascular Clamps
Yes ❑ No ❑	Metal in Eyes
Yes ❑ No ❑	Ear Implant Surgery
Yes ❑ No ❑	Insertable Loop Recorder System (Reveal ILR monitors heart rhythm and rate for fainting spells)
Yes ❑ No ❑	Aneurysm Clips
Yes ❑ No ❑	Bullets, Shrapnel If yes: Where is it located?
Yes ❑ No ❑	Stents
Yes ❑ No ❑	Do you have any metal or implants in your body due to surgery, injury or due to a medical condition?
Yes ❑ No ❑	Penile Implants or Breast Tissue Expanders or Implants, Contraception Devices (IUD, diaphragm, etc.)
Yes ❑ No ❑	Dentures and/or Hearing Aids
Yes ❑ No ❑	Tattoos, Permanent Cosmetics (eyeliner, etc.)
Yes ❑ No ❑	Body Piercing If yes: Location of piercing(s)?
Yes ❑ No ❑	Transdermal Patches
Yes ❑ No ❑	Hairpieces, Wigs, Hairpins
Yes ❑ No ❑	Do you have a history of seizures?
Yes ❑ No ❑	Are you allergic to or had any reactions to medications or food?
Yes ❑ No ❑	Colonoscopy in the last 6 weeks?

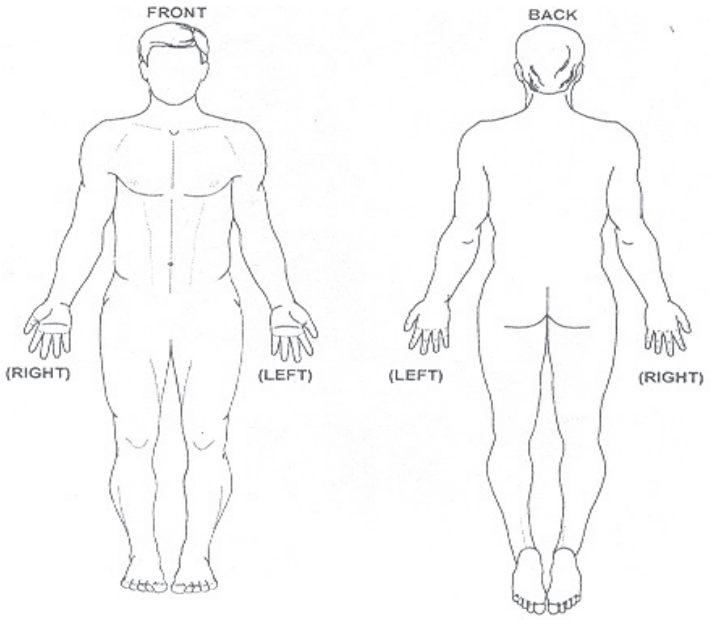
THIS SECTION ONLY FOR PATIENTS USING ORAL SEDATION

Yes ❑ No ❑ Have you taken oral sedation (prescription or over the counter medication) for today's MRI? If yes: Please note medication name, dose amount and time taken: _____

I confirm that I have a designated driver to take me home today following my MRI: _____
(patient's initials)

(OVER)

Please shade the area you are experiencing pain:



OFFICE USE ONLY:

Creatinine _____

Date _____

GFR _____

GAD _____

Indicate *Yes* or *No* for the following questions.

Yes ❑ No ❑	Is this a result of an injury? If yes: When did injury occur?
	Location of pain? Front ❑ Back ❑ Inside ❑ Outside ❑ All over ❑ How long have you had these symptoms?
Yes ❑ No ❑	Do you have Rheumatoid Arthritis?
Yes ❑ No ❑	Do you have an infection in the area we are scanning?
Yes ❑ No ❑	Have you ever been diagnosed with cancer or currently going through treatment? If yes: Type of cancer? When?
Yes ❑ No ❑	Have you had any previous x-rays, CT scans or MRI scans **of the area being scanned?** If yes: When? Where?
Yes ❑ No ❑	Have you had any previous surgeries **of the area being scanned?** If yes: When? Where?

List any additional information that may be useful for our radiologist:

_____

_____

_____

I understand that my physician has ordered a MRI and the above information is correct.
I may be asked to change into appropriate attire for the MRI and my personal items will be locked up for safekeeping. At that time all my questions will be answered.

_____ _____

Patient's Signature Date Technologist Initials