ATHENS Bone & Joint
ORTHOPEDIC CLINIC

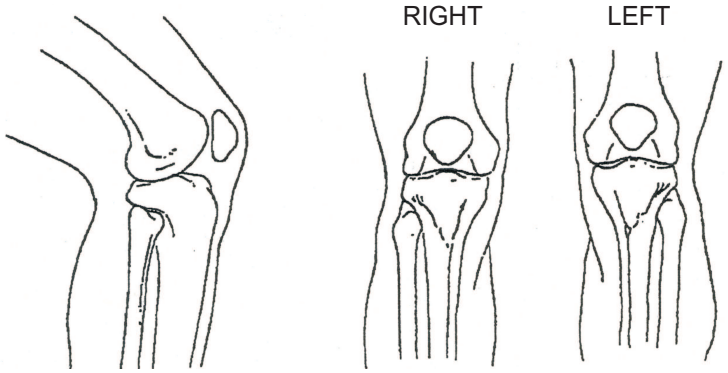
Knee MRI Patient History

Patient's Name:	Date

Which knees are painful?
(check one box please)

- ☐ Right knee
- ☐ Left knee
- ☐ Both knees

Draw arrows to areas of pain.



Have you had an injury to your knee recently? ☐ Yes ☐ No

If so, please describe injury:

When did this injury occur?

Please check all that apply to your injury:

☐ Knee twisted ☐ Knee pulled forward or backward ☐ hurt running ☐ Lifting heavy articles ☐ Knee impacted hard surface

Does your knee ever lock? ☐ Yes ☐ No

Does your knee ever give away? ☐ Yes ☐ No

Have you had surgery on your knee (s)? ☐ Yes ☐ No

If so, what kind of surgery?

When?

Have you had any of the following procedures done on your (checked box above)?

Routine X-rays	☐ Yes ☐ No	Where?	When?
Bone Scan	☐ Yes ☐ No	Where?	When?
Cat Scan	☐ Yes ☐ No	Where?	When?
Arthrogram	☐ Yes ☐ No	Where?	When?
MRI	☐ Yes ☐ No	Where?	When?
Other	☐ Yes ☐ No	Where?	When?

Do you have a mass or growth on your knee? ☐ Yes ☐ No

If so, how long has it been there?

Where is it located?

Allergies?

Please list all allergies

Have you ever had an injection of any kind into your joint? ☐ Yes ☐ No

What type of injection?

Date of Injection:

Patient History and Safety Screening

Patient's Name:	Age:	Weight:

The folllowing items can interfere with MR Imaging and some may be Hazardous to our safety.

ATTENTION: MR Patients and Accompanying Family Members the MR room contains a very strong magnet. Before you are allowed to enter, we must know if you have metal in your body. Some metal objects can interfere with your scan or even be dangerous, so please answer the following questions carefully.

Have you ever had an operation or surgical procedure of any kind? ☐ Yes ☐ No
Please list all with dates:

Procedure:	Date:
Procedure:	Date:
Procedure:	Date:
Procedure:	Date:

Have you ever been a machinist, welder, or metal-worker? ☐ Yes ☐ No

Have you ever been hit in the face or eye with a piece of metal (including metal shavings, slivers, bullets or BBs)? ☐ Yes ☐ No

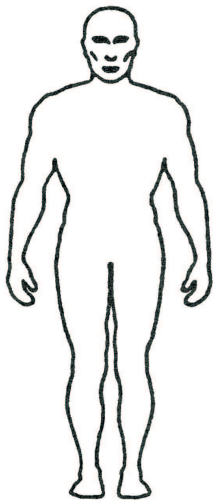
Have you ever had a piece of metal removed from your eye? ☐ Yes ☐ No

Are you pregnant, possibly pregnant, or breast feeding? ☐ Yes ☐ No

Are you wearing a skin medication patch? ☐ Yes ☐ No

Please mark on this drawing the location of any metal inside your body:

RIGHT



LEFT

DO YOU HAVE ANY OF THESE ITEMS IN YOUR BODY?

☐ Yes ☐ No Pacemaker, wires or defibrillator

☐ Yes ☐ No Brain / aneurysm clip

If you have a Pacemaker you CANNOT have a MRI

☐ Yes ☐ No — Ear implant
☐ Yes ☐ No — Eye implant
☐ Yes ☐ No — Electrical stimulator for nerves or bones
☐ Yes ☐ No — Bullets, BBs, or pellets
☐ Yes ☐ No — Metal Shrapnel or fragments
☐ Yes ☐ No — Magnetic implants anywhere
☐ Yes ☐ No — Infusion pump
☐ Yes ☐ No — Coil, filter or wire in blood vessel
☐ Yes ☐ No — Artificial limb or joint
☐ Yes ☐ No — Eyelid tattoo
☐ Yes ☐ No — Implanted catheter, tube or stint
☐ Yes ☐ No — Artificial heart valve
☐ Yes ☐ No — Shunt
☐ Yes ☐ No — False teeth, retainers, or magnetic braces
☐ Yes ☐ No — Surgical clips, staples, wires, mesh or sutures
☐ Yes ☐ No — Diaphragm or intrauterine device
☐ Yes ☐ No — Orthopedic hardware (plates, screws, pins, rods or wires)

The following items may become damaged or cause injury to others in a strong magnetic field.

THEY MUST NOT BE TAKEN INTO THE MR SCAN ROOM

- Hearing Aid
- Glasses
- Watch
- Safety Pins
- Hairpins/Barrettes
- Wigs/Hair pieces
- Jewelry (Rings, earrings, etc.)
- Wallet/Money clip
- Purse/Pocketbook
- Pens/Pencils
- Artificial limb/Prosthesis
- Keys
- Coins
- Pocketknife
- Credit or Bank cards
- Dentures/partial plates
- Retainers
- Belt buckle
- Bra, girdle, sanitary belt
- Metal zippers/Buttons

(Please explain to technologist in private prior to entering the MRI suite.

Comments:

Signature Patient/Guardian	Date:

ATHENS Bone & Joint
ORTHOPEDIC CLINIC

Spine MRI Patient History

Patient's Name:	Date

Have you had an injury to your spine? ☐ Yes ☐ No If so, please describe injury:

Do you have

Low Back Pain?	☐ Yes ☐ No	If so, how long?		
Leg Pain?	☐ Yes ☐ No	If so, how long?	Which leg(s)?	
Mid Back Pain?	☐ Yes ☐ No	If so, how long?		
Neck Pain?	☐ Yes ☐ No	If so, how long?		
Arm Pain?	☐ Yes ☐ No	If so, how long?	Which arm(s)?	

Have you had any previous cervical spine (neck) surgery? ☐ Yes ☐ No If so, level of operation: When?

Have you had any previous Thoracic (mid back) surgery? ☐ Yes ☐ No If so, level of operation: When?

Have you had any previous lumbar spine (low back) surgery? ☐ Yes ☐ No If so, level of operation: When?

Have you had any of the following procedures done on your (checked box above)?

Routine X-rays	☐ Yes ☐ No	Where?	When?
Bone Scan	☐ Yes ☐ No	Where?	When?
Cat Scan	☐ Yes ☐ No	Where?	When?
Myelogram	☐ Yes ☐ No	Where?	When?
MRI	☐ Yes ☐ No	Where?	When?
Other	☐ Yes ☐ No	Where?	When?

Do you have any kind of cancer that you know of? ☐ Yes ☐ No If so, what kind:

Have you had any kind of radiation of chemotherapy treatments? ☐ Yes ☐ No Approximate date of radiation: Approximate date of chemotherapy:

Allergies?

Please list all allergies

Additional Comments:

Patient History and Safety Screening

Patient's Name:	Age:	Weight:

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Have you ever had an operation or surgical procedure of any kind? ☐ Yes ☐ No
Please list all with dates:

Procedure:	Date:
Procedure:	Date:
Procedure:	Date:
Procedure:	Date:

Have you ever been a machinist, welder, or metal-worker? ☐ Yes ☐ No

Have you ever been hit in the face or eye with a piece of metal (including metal shavings, slivers, bullets or BBs)? ☐ Yes ☐ No

Have you ever had a piece of metal removed from your eye? ☐ Yes ☐ No

Are you pregnant, possibly pregnant, or breast feeding? ☐ Yes ☐ No

Are you wearing a skin medication patch? ☐ Yes ☐ No

Please mark on this drawing the location of any metal inside your body:

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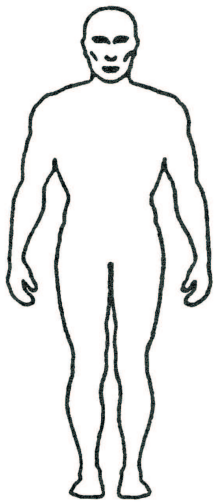

LEFT

DO YOU HAVE ANY OF THESE ITEMS IN YOUR BODY?

☐ Yes ☐ No Pacemaker, wires or defibrillator

☐ Yes ☐ No Brain / aneurysm clip

If you have a Pacemaker you CANNOT have a MRI

☐ Yes ☐ No — Ear implant
☐ Yes ☐ No — Eye implant
☐ Yes ☐ No — Electrical stimulator for nerves or bones
☐ Yes ☐ No — Bullets, BBs, or pellets
☐ Yes ☐ No — Metal Shrapnel or fragments
☐ Yes ☐ No — Magnetic implants anywhere
☐ Yes ☐ No — Infusion pump
☐ Yes ☐ No — Coil, filter or wire in blood vessel
☐ Yes ☐ No — Artificial limb or joint
☐ Yes ☐ No — Eyelid tattoo
☐ Yes ☐ No — Implanted catheter, tube or stint
☐ Yes ☐ No — Artificial heart valve
☐ Yes ☐ No — Shunt
☐ Yes ☐ No — False teeth, retainers, or magnetic braces
☐ Yes ☐ No — Surgical clips, staples, wires, mesh or sutures
☐ Yes ☐ No — Diaphragm or intrauterine device
☐ Yes ☐ No — Orthopedic hardware (plates, screws, pins, rods or wires)

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- Wallet/Money clip
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- Artificial limb/Prosthesis
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- Pocketknife
- Credit or Bank cards
- Dentures/partial plates
- Retainers
- Belt buckle
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Comments:

Signature Patient/Guardian	Date:

ATHENS Bone & Joint
ORTHOPEDIC CLINIC

MRI Patient History

Ankle ☐
Elbow ☐
Foot ☐
Hip ☐
Shoulder ☐
Wrist ☐

Patient's Name:

Date

Do you have pain in your (checked box above)? ☐ Yes ☐ No

If so, which (checked box above)?

How long have you had pain in your (checked box above)?

Have you had surgery on your (checked box above)? ☐ Yes ☐ No

If so, what kind of surgery?

When?

Have you had an injury to your (checked box above)? ☐ Yes ☐ No If so, please describe injury:

Do you have any type of cancer that you know of?

Do you have rheumatoid arthritis?

Have you had any of the following procedures done on your (checked box above)?

Routine X-rays	☐ Yes ☐ No	Where?	When?
Bone Scan	☐ Yes ☐ No	Where?	When?
Cat Scan	☐ Yes ☐ No	Where?	When?
Arthrogram	☐ Yes ☐ No	Where?	When?
MRI	☐ Yes ☐ No	Where?	When?
Other	☐ Yes ☐ No	Where?	When?

Do you have a history of using steroids? ☐ Yes ☐ No If so, please explain:

Do you have kidney disease? ☐ Yes ☐ No

Have you had a kidney transplant? ☐ Yes ☐ No If so, when?

Do you have a mass or growth? ☐ Yes ☐ No If so, how long has it been there? Where is it located?

Is there any other information that you think is important?

Allergies?

Please list all allergies

Have you ever had an injection of any kind into your joint? ☐ Yes ☐ No What type of injection? Date of Injection:

Patient History and Safety Screening

Patient's Name:	Age:	Weight:

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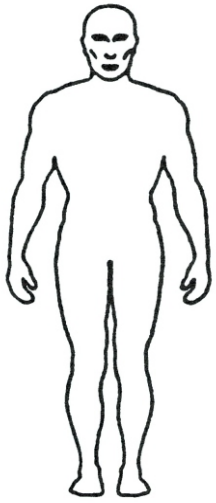

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