
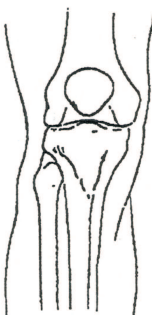
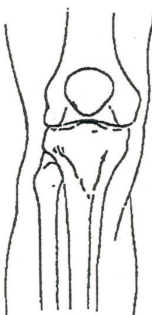



Patient's Name:	Date
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Which knees are painful? (check one box please)	RIGHT	LEFT
<input type="checkbox"/> Right knee <input type="checkbox"/> Left knee <input type="checkbox"/> Both knees		
Draw arrows to areas of pain.		

Have you had an injury to your knee recently? <input type="checkbox"/> Yes <input type="checkbox"/> No	If so, please describe injury:	When did this injury occur?
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Please check all that apply to your injury:				
<input type="checkbox"/> Knee twisted	<input type="checkbox"/> Knee pulled forward or backward	<input type="checkbox"/> hurt running	<input type="checkbox"/> Lifting heavy articles	<input type="checkbox"/> Knee impacted hard surface

Does your knee ever lock? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does your knee ever give away? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you had surgery on your knee (s)? <input type="checkbox"/> Yes <input type="checkbox"/> No
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If so, what kind of surgery?	When?
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Have you had any of the following procedures done on your (checked box above)?			
Routine X-rays	<input type="checkbox"/> Yes <input type="checkbox"/> No	Where?	When?
Bone Scan	<input type="checkbox"/> Yes <input type="checkbox"/> No	Where?	When?
Cat Scan	<input type="checkbox"/> Yes <input type="checkbox"/> No	Where?	When?
Arthrogram	<input type="checkbox"/> Yes <input type="checkbox"/> No	Where?	When?
MRI	<input type="checkbox"/> Yes <input type="checkbox"/> No	Where?	When?
Other	<input type="checkbox"/> Yes <input type="checkbox"/> No	Where?	When?

Do you have a mass or growth on your knee? <input type="checkbox"/> Yes <input type="checkbox"/> No	If so, how long has it been there?	Where is it located?
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Allergies?		
Please list all allergies		

Have you ever had an injection of any kind into your joint? <input type="checkbox"/> Yes <input type="checkbox"/> No	What type of injection?	Date of Injection:
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Patient History and Safety Screening

Patient's Name:	Age:	Weight:
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The following 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.

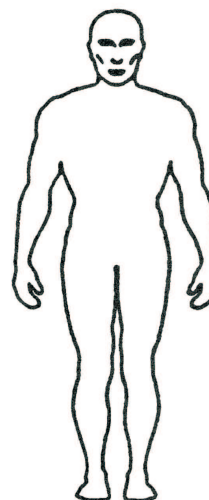
Have you ever had an operation or surgical procedure of any kind? Yes No
Please list all with dates:

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

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

RIGHT

LEFT



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

DO YOU HAVE ANY OF THESE ITEMS IN YOUR BODY?

If you have a Pacemaker you CANNOT have a MRI

Yes No Pacemaker, wires or defibrillator

Yes No Brain / aneurysm clip

- 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

<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • Keys • Coins • Pocketknife • Credit or Bank cards • Dentures/partial plates • Retainers • Belt buckle • Bra, girdle, sanitary belt • Metal zippers/Buttons
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(Please explain to technologist in private prior to entering the MRI suite.)

Comments:

Signature Patient/Guardian	Date:
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ORTHOPEDIC CLINIC

Spine MRI Patient History

Patient's Name:	Date
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Have you had an injury to your spine? Yes No If so, please describe injury:

Do you have

Low Back Pain?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If so, how long?	
Leg Pain?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If so, how long?	Which leg(s)?
Mid Back Pain?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If so, how long?	
Neck Pain?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If so, how long?	
Arm Pain?	<input type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/> Yes <input type="checkbox"/> No	Where?	When?
Bone Scan	<input type="checkbox"/> Yes <input type="checkbox"/> No	Where?	When?
Cat Scan	<input type="checkbox"/> Yes <input type="checkbox"/> No	Where?	When?
Myelogram	<input type="checkbox"/> Yes <input type="checkbox"/> No	Where?	When?
MRI	<input type="checkbox"/> Yes <input type="checkbox"/> No	Where?	When?
Other	<input type="checkbox"/> Yes <input type="checkbox"/> 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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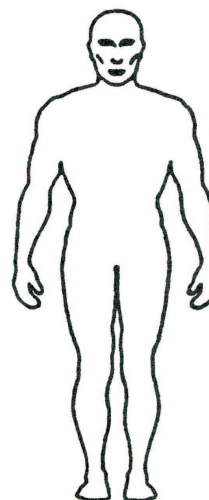
Have you ever had an operation or surgical procedure of any kind? Yes No
Please list all with dates:

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

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

RIGHT

LEFT



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

DO YOU HAVE ANY OF THESE ITEMS IN YOUR BODY?

If you have a Pacemaker you CANNOT have a MRI

Yes No Pacemaker, wires or defibrillator

Yes No Brain / aneurysm clip

- 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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Comments:

Signature Patient/Guardian	Date:
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- Ankle
- Elbow
- Foot
- Hip
- Shoulder
- Wrist

Patient's Name:	Date
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Do you have pain in your (checked box above)? <input type="checkbox"/> Yes <input type="checkbox"/> No	If so, which (checked box above)?
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How long have you had pain in your (checked box above)?	Have you had surgery on your (checked box above)? <input type="checkbox"/> Yes <input type="checkbox"/> No
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If so, what kind of surgery?	When?
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Have you had an injury to your (checked box above)? <input type="checkbox"/> Yes <input type="checkbox"/> No	If so, please describe injury:
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Do you have any type of cancer that you know of?
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Do you have rheumatoid arthritis?

Have you had any of the following procedures done on your (checked box above)?			
Routine X-rays	<input type="checkbox"/> Yes <input type="checkbox"/> No	Where?	When?
Bone Scan	<input type="checkbox"/> Yes <input type="checkbox"/> No	Where?	When?
Cat Scan	<input type="checkbox"/> Yes <input type="checkbox"/> No	Where?	When?
Arthrogram	<input type="checkbox"/> Yes <input type="checkbox"/> No	Where?	When?
MRI	<input type="checkbox"/> Yes <input type="checkbox"/> No	Where?	When?
Other	<input type="checkbox"/> Yes <input type="checkbox"/> No	Where?	When?

Do you have a history of using steroids?	If so, please explain:
<input type="checkbox"/> Yes <input type="checkbox"/> No	

Do you have kidney disease?	Have you had a kidney transplant?	If so, when?
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Do you have a mass or growth?	If so, how long has it been there?	Where is it located?
<input type="checkbox"/> Yes <input type="checkbox"/> No		

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?	What type of injection?	Date of Injection:
<input type="checkbox"/> Yes <input type="checkbox"/> No		

Patient History and Safety Screening

Patient's Name:	Age:	Weight:
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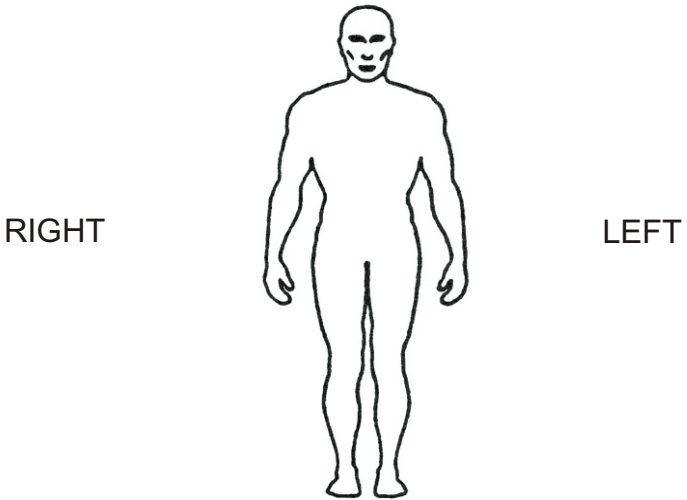
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Are you pregnant, possibly pregnant, or breast feeding? Yes No

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DO YOU HAVE ANY OF THESE ITEMS IN YOUR BODY?

Yes No Pacemaker, wires or defibrillator

Yes No Brain / aneurysm clip

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- 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
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Comments:

Signature Patient/Guardian	Date:
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