

MSK EVALUATION

Last Name:	First:	Date:
_____	_____	_____

THESE QUESTIONS APPLY ONLY TO THE AREA BEING SCANNED TODAY

1. Have you had an MRI or CT scan of this body part previously? Yes No
• If so, where and when?

2. What do you think is wrong? _____

3. Describe your symptoms:

4. What makes it better? _____

5. What makes it worse? _____

6. Do you have areas of weakness? Yes No Weakness where? _____

7. Any surgery/arthroscopy on the scan area? Yes No Date of surgery? _____
What was done in surgery? _____

8. Do you have arthritis in any of your joints? Yes No List joints: _____

9. Are you currently taking any medications? Yes No List medications: _____

10. Do you have any other medical conditions? Yes No List conditions: _____

11. List athletic activities that may have contributed to your condition: _____

12. Have you ever had cancer? Yes No If yes, what type? _____
Have you undergone chemotherapy, radiation therapy or surgery for cancer? Yes No
If yes, what type of cancer treatment have you had? _____

Dates of cancer treatments: _____
13. Have you had an injury to the area being scanned today? (e.g. car accident, fall, etc.) Yes No
If yes, date of injury/trauma _____
14. Is there any other information about the area being scanned today that the radiologist should know about? _____

Please fill out back of this form





MRI SAFETY SCREENING QUESTIONNAIRE

Weight _____

Please provide a "yes" or "no" answer for every item

YES NO

- Heart pacemaker or implanted cardioverter defibrillator (ICD)
- Aneurysm clip/coil Date of implant: _____
- Internal electrodes or wires (pacing wires, DBS or VNS wires)
- Eye injury from a metal object (metal shavings, metal slivers)
- Artificial eye and/or eyelid spring
- Electronic implant/device or magnetically activated implant/device
- Neurostimulator/spinal cord stimulator/bone growth stimulator/deep brain
- Implanted drug pump (chemotherapy, pain medicine) External drug pump
- Metallic stent If yes, what kind _____ Date of Implant: _____
- Cochlear implant, middle ear implant
- Artificial heart valve, coil, filter If yes, then list _____
- Prosthesis of any kind (eye, ear, penile, limb) If yes, then list _____
- Shunt programmable/adjustable shunt or a non-programmable shunt
- Injured by a metal object (shrapnel, bullet, BB)
- Medication patch (nitroglycerin, nicotine, contraceptive, estrogen)
- Breast tissue expander
- Surgical clips, staples or mesh implants
- Implanted post-surgical hardware (pins, rods, screws, plates, wires)
- False teeth/dentures, partial plates, removable dental work, braces, retainer
- Body piercing jewelry, tattoos, permanent makeup
- Hearing aid(s) *Remove prior to entering MRI room*
- Other Implant If yes, then list _____

For patient getting contrast: Do you have a history of:

- | | | | | | |
|--------------------------|--------------------------|---|--------------------------|--------------------------|--------------------------|
| Yes | No | | Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney disease | <input type="checkbox"/> | <input type="checkbox"/> | Liver disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Chemotherapy in last 30 days | <input type="checkbox"/> | <input type="checkbox"/> | Allergic to MRI contrast |
| <input type="checkbox"/> | <input type="checkbox"/> | <i>Female patients only:</i> Are you pregnant or breast feeding? | | | |

I attest that the above information is correct to the best of my knowledge. I have read and understand the contents of this form and have had the opportunity to ask questions regarding the information on this form and regarding the MR procedure that I am about to undergo.

PATIENT SIGNATURE	DATE
PERSON COMPLETEING THE FORM/RELATIONSHIP TO PATIENT	TECHNOLOGIST INITIALS:

Copy of report to any other physicians: _____