SPINE 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 was your chief complaint when you visited your doctor?_____
_____

3. What does your doctor think is causing your symptoms?_____

4.How long have you had these symptoms?_____

5. Do your symptoms involve your arm(s)? Yes □ No □ **If yes**: LEFT, RIGHT or BOTH? (circle)
Are the symptoms in your arm(s) in the FRONT, BACK and/or SIDE? (circle)

6. Do your symptoms involve your leg(s)? Yes □ No □ **If yes**: LEFT, RIGHT or BOTH? (circle)
Are the symptoms in your leg(s) in the FRONT, BACK and/or SIDE? (circle)

7. Do you have any numbness? Yes □ No □ Where?_____

8. Do you have areas of weakness? Yes □ No □ Where?_____

9. Have you had any bowel or bladder changes? Yes □ No □

10. Any surgery/arthroscopy on your spine? Yes □ No □ When? _____
What was done in surgery? _____

11. 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:_____

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

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

California Pacific Advanced Imaging

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	
☐	☐	Kidney disease	☐	☐	Liver disease
☐	☐	Diabetes	☐	☐	High Blood Pressure
☐	☐	Chemotherapy in last 30 days	☐	☐	Allergic to MRI contrast
☐	☐	*Female patients only*: 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:**_____