

NORTH TEXAS ORTHOPEDICS MRI HISTORY AND SAFETY SHEET

Exam Date: _____ Exact Weight: _____ (LBS) (required) Is This Your First MRI? YES NO

Last Name: _____ First Name: _____

D.O.B. _____ :Age: _____ Sex: M/F What Is Your Level of Pain Today? 1 2 3 4 5

CHECK: YES (Y) OR NO (N) FOR EACH ITEM

Y N	Y N	Y N
<input type="checkbox"/> <input type="checkbox"/> Brain or heart surgery (CIRCLE)	<input type="checkbox"/> <input type="checkbox"/> Cardiac pacemaker, or defibrillator	<input type="checkbox"/> <input type="checkbox"/> Seizures: Date of last seizure: _____
<input type="checkbox"/> <input type="checkbox"/> Neuro or bone stimulator	<input type="checkbox"/> <input type="checkbox"/> Artificial heart valve: Type: _____	<input type="checkbox"/> <input type="checkbox"/> Drug allergies
<input type="checkbox"/> <input type="checkbox"/> Drug infusion pump or device	<input type="checkbox"/> <input type="checkbox"/> Disease that affects your blood	<input type="checkbox"/> <input type="checkbox"/> Aneurysm or other surgical clip(s)
<input type="checkbox"/> <input type="checkbox"/> Renal disease	<input type="checkbox"/> <input type="checkbox"/> Penile implants	<input type="checkbox"/> <input type="checkbox"/> Stent(s) Year: _____
<input type="checkbox"/> <input type="checkbox"/> Embolization coil(s) or filter(s)	<input type="checkbox"/> <input type="checkbox"/> Respiratory disease	<input type="checkbox"/> <input type="checkbox"/> Lasik, Crystal lens, eye implants
<input type="checkbox"/> <input type="checkbox"/> Cochlear (ear) implants	<input type="checkbox"/> <input type="checkbox"/> On claustrophobia medicine today	<input type="checkbox"/> <input type="checkbox"/> Claustrophobia: Y/N
<input type="checkbox"/> <input type="checkbox"/> Metal in body: Location: _____	<input type="checkbox"/> <input type="checkbox"/> Shrapnel, bullets, pellets, b.b's.	<input type="checkbox"/> <input type="checkbox"/> Transdermal medication patch
<input type="checkbox"/> <input type="checkbox"/> Body/cosmetic piercing	<input type="checkbox"/> <input type="checkbox"/> Metal fragments removed from eyes	<input type="checkbox"/> <input type="checkbox"/> Insulin pump
<input type="checkbox"/> <input type="checkbox"/> Tattoo(s)	<input type="checkbox"/> <input type="checkbox"/> Hearing aids	<input type="checkbox"/> <input type="checkbox"/> Restless leg syndrome
<input type="checkbox"/> <input type="checkbox"/> Removable dental appliances	<input type="checkbox"/> <input type="checkbox"/> Allergy to contrast media: CT/MRI	<input type="checkbox"/> <input type="checkbox"/> Dental implants

ANYTHING NOT LISTED ABOVE: _____

*******REQUIRED*******

- Where does it hurt? Circle: Front Back Inside Outside Describe: _____
- How long has it been hurting? _____
- Was there a workout injury or other accident? Describe: _____ How long? _____
- Have you had surgery on the area being scanned today? NO YES If yes, list surgery and the year: _____
- Personal history of cancer? Type: _____ Year Diagnosed: _____ Chemo Radiation Surgery

*******FOR WOMEN ONLY: Mark Two Boxes*******

Hysterectomy Tubal ligation Ablation Intra-uterine device (IUD) Birth control Abstinence Essure Condoms Partner vasectomy
 Post-menopausal Peri-menopausal Pregnant or trying to conceive

Date of last period: _____ (mm/dd/yyyy) Infertility Breast feeding Other: (List) _____

CONSENT FOR MAGNETIC RESONANCE IMAGING STUDY

All questions this examination were explained to my satisfaction. I understand that certain metal objects which may be in my body can be influenced by the magnetic field and that their movement within my body may cause serious consequences. I understand that I may terminate this examination at any time and that the examination will be conducted by specially trained medical personnel. I give my permission for this examination to be performed. (If patient is a minor or unable to sign, parent or guardian to sign.) I acknowledge, to the best of my understanding, that the answers herein are true.

Patient or Parent/Guardian Signature: _____ Exam Date: _____

When going in for your MRI, please leave all of your belongings in the dressing room (purses, wallets, keys, cell phones, jewelry, credit cards, and other metallic or magnetic strip items). POCKETS SHOULD BE COMPLETELY EMPTY. The dressing room will be locked during your exam.

Please sign below acknowledging that you have read this form and that it was explained to you by the technologist.

Patient or Parent/Guardian Signature: _____ Date: _____

OFFICE USE ONLY:

Exam: _____ Diagnosis: _____
Exam: _____ Diagnosis: _____
Exam: _____ Diagnosis: _____
Technologist: _____ Adair L. Casterline BHS R.T.(R)(MR)(CT)(QM)(M)
Technologist Signature: _____ Exam Date: _____