MRI LOWER EXTREMITY
PATIENT HISTORY AND SCREENING

Name: _____ Referring Physician: _____

Please explain your present complaint or problem in detail _____

_____

Is this problem a result of an injury? ❑ No ❑ Yes
If so, how did it occur? _____
How long have you had this problem? _____
Previous injury or surgery to this area? ❑ No ❑ Yes When? _____

If yes, please explain what was done _____

_____

Please check if you have any of the following:

_____ Lump or mass	_____ Steroid therapy	_____ Fever	_____ Gout
_____ Dislocation	_____ Radiation therapy	_____ Cancer	_____ High BP
_____ Numbness	_____ Kidney disease	_____ Diabetes	
_____ Weakness	_____ Liver disease		

If you checked anything listed above, please explain _____

_____

Does anything make the pain/condition worse? ❑ No ❑ Yes Explain _____

_____

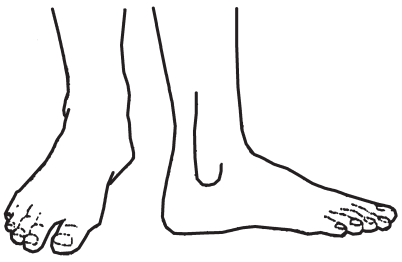
Does anything make the pain/condition better? ❑ No ❑ Yes Explain _____

_____

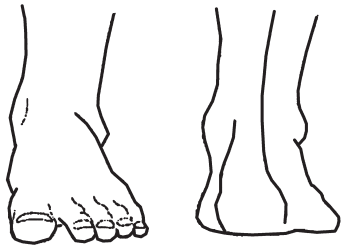
Have you had any previous exams of the body part being scanned today? ❑ No ❑ Yes
If yes, what type of exam? _____
When and where? _____

Please circle/shade the area where you are having problems on the picture below.

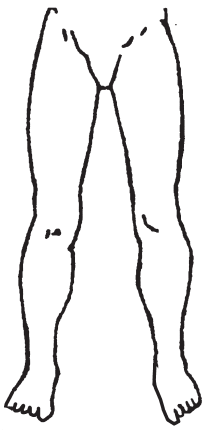
Right Foot



Left Foot



Right Left



(please turn over)

PATIENT MRI SAFETY SCREENING FORM

Name_____ Weight_____

Date of Birth_____ Last menstrual period_____ ❑ N/A

Please check any that apply:
Possibly pregnant? ❑ Yes Claustrophobic (afraid of closed in areas)? ❑ Yes
Have you **EVER** worked around metal grinding/filing or welding? ❑ Yes
Have you **EVER** had metal particles in your eyes? ❑ Yes

Please list any surgeries you have had _____

_____

Please list any known allergies to latex, tape or drugs that you have: _____

Do you have history of renal disease or dialysis? ❑ No ❑ Yes

The following items ***can*** interfere with MR imaging and ***can*** be hazardous to your safety. Please check appropriate items & notify the Technologist if you have any of the following:

_____Cardiac pacemaker	_____Hearing aids	_____Brain clips
_____Cochlear implants	_____Aortic clips	_____Shunts
_____Carotid clips	_____Joint replacements	_____Neurostimulators (Tens)
_____Harrington rod	_____Heart valve replacements	_____Bone or joint pins
_____Insulin pump	_____Prosthesis	_____Electrodes
_____Wire sutures	_____Metal mesh	_____Shrapnel
_____Metal plates	_____Dental/teeth work with magnets	_____Stents
	_____Therapeutic Magnets or screws, nails or metal rods	

_____Other (please list) _____

DO NOT ENTER THE SCANNING ROOM WITH ANY OF THE FOLLOWING ITEMS:
Hearing aids, Magnetic strip cards (credit cards, bank cards), Jewelry, Hairpins/barrettes, Glasses, Watch, Wallet/Money Clip, Pocketknife, Safety pins, Pens/pencils, Phone/pager, Keys, Coins

**** Lockers will be provided to lock patient valuables ****

I have reviewed and confirmed that the above information is complete to the best of my knowledge:

Pt. Signature_____ **Date**_____

Please turn form over for additional information

MRI Technologist has interviewed patient:_____Tech