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 Leg     Left Leg

(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
Other (please list) Therapeutic Magnets or screws, nails or metal rods

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