

MRI UPPER EXTREMITY PATIENT HISTORY AND SCREENING

Name: _____ Referring Physician: _____

Please explain your present complaint or problem in detail _____

How long have you had this problem? _____

Any previous injury or surgery to this area? No Yes If yes, when? _____

If yes, please explain what was done _____

Please check if you have any of the following:

- | | | | |
|--------------------|-------------------------|-------------------------------|----------------|
| _____ Lump or mass | _____ Weakness | _____ Fever | _____ Cancer |
| _____ Dislocation | _____ Steroid therapy | _____ HTN | _____ Diabetic |
| _____ Numbness | _____ Radiation therapy | _____ Kidney or 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? _____

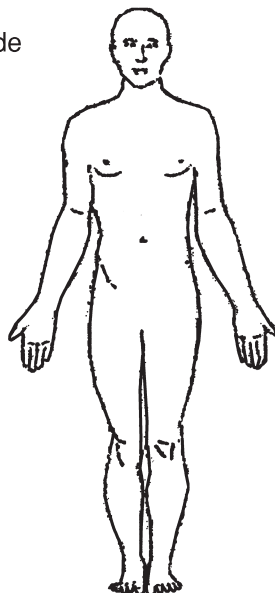
Please circle/shade the area where you are having problems on the picture below.

Right Side

Left Side

Right Arm

Left Arm



(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