

St. Peters Bone & Joint Surgery

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GENERAL ORTHOPEDICS • SPINE • SPORTS MEDICINE
FOOT & ANKLE SURGERY • JOINT REPLACEMENT • HAND SURGERY

Patient History and Screening Form for MRI

Patient Name: _____ DOB: _____

DO YOU HAVE ANY OF THE FOLLOWING?

	Yes	No		Yes	No
Cardiac Pacemaker	___	___	Diabetes	___	___
Pacemaker Lead	___	___	Denture	___	___
Artificial heart valve	___	___	Hearing Aid	___	___
Previous heart surgery	___	___	Neurostimulator (Tens-Unit)	___	___
IVC umbrella filter	___	___	Metal pins / screws	___	___
Aneurysm clips	___	___	Lens Implant	___	___
Previous brain surgery	___	___	Infusion pump	___	___
Ear implants	___	___	Shunts	___	___
Employed as metal worker	___	___	Harrington rod	___	___
Metal splinters / fragments	___	___	IUD	___	___
Shrapnel-bullets-shot	___	___	Are you Pregnant	___	___
Prosthesis	___	___	History of Cancer (explain below)	___	___
Neck or Back surgery	___	___	Previous MRI	___	___
Metal Joint Replacement	___	___	Bone Stimulator	___	___

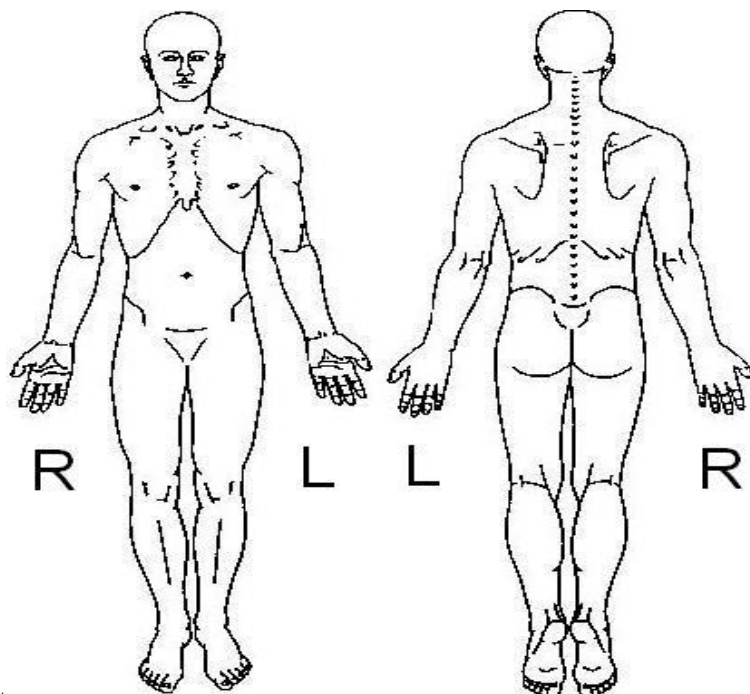
What Symptoms / Problems are you having?

Is this a result of Injury? No Yes

If yes, Please explain: _____

List previous surgeries / history of cancer:

Please indicate your areas of pain on the figures.



Patient / Parent / Legal Guardian

Date

Technologist / Witness Signature

Previous MRI Report scanned in Yes No

Previous Op Note scanned in Yes No

CONSENT: I have informed the technologist that aneurysm clips in my body or metallic foreign bodies in my eyes. I have answered these questions to the best of my knowledge and understand the information presented to me I have also informed the technologist that I am not pregnant at this time