



For Office Use Only

Date _____
Account # _____
F/U Appt w/Ref MD _____

Please Print

NAME _____ SOCIAL SECURITY # _____
Last, First, Middle

AGE _____ BIRTHDATE _____ HEIGHT _____ WEIGHT _____ SEX: M F

EMERGENCY CONTACT: NAME _____ NUMBER _____

FEMALES: Are you pregnant? YES NO When was your last menstrual period? _____ Are you breastfeeding? _____

REFERRING JEWETT PHYSICIAN _____

Briefly describe your problem/pain and how long you have had these symptoms? _____

DATE OF INJURY (IF APPLICABLE) _____

HAVE YOU HAD **SURGERY OR RADIATION THERAPY** IN THE AREA TO BE SCANNED? ? YES NO

IF YES, DESCRIBE WHAT WAS DONE AND WHEN THE SURGERY WAS PERFORMED _____

IF SURGERY, ARE YOUR SYMPTOMS : BETTER WORSE SAME DIFFERENT (CIRCLE AND DESCRIBE)

HAVE YOU HAD ANY OF THE FOLLOWING STUDIES PERTAINING TO TODAYS EXAM? IF SO, INDICATE BELOW.

TEST	WHEN	WHAT FACILITY	RESULTS
X-rays			
CT Scan			
MRI Scan			
Ultrasound			
Nuclear Medicine			
Therapeutic Injection			
Arthrogram			

INDICATE SYMPTOMS:

Please check: RIGHT LEFT BOTH

Arm Pain			
Neck Pain			
Back Pain			
Leg Pain			
Tingling			
Weakness			
Numbness			

PAIN LOC: _____

DURATION: _____

SURG: _____

PREVIOUS IMAGING: _____

INJURY DATE: _____

ADD. INFO: _____

C2/3 =

C3/4 =

C4/5 =

C5/6 =

C6/7 =

C7/T1 =

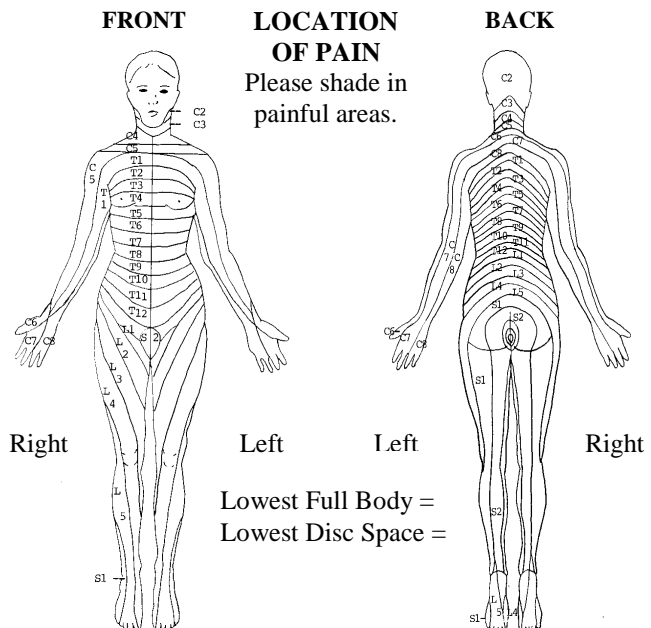
T12/L1 =

L1/2 =

L2/3 =

L3/4 =

L4/5 =



T1/2 =

T2/3 =

T3/4 =

T4/5 =

T5/6 =

T6/7 =

T7/8 =

T8/9 =

T9/10 =

T10/11 =

T11/12 =

T12/L1 =

JEWETT ORTHOPAEDIC, P.A. - MRI Check List

Dear Patient – **Please answer these questions carefully!** Your answers to the following questions will help us to determine whether this MRI examination is safe for you based on your history. In addition, we need to determine whether the items asked below may interfere with your study or may cause difficulty with the scan results. Please indicate your answer for each of the following questions to the best of your knowledge.

Do you have a cardiac (heart) pacemaker or wires?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you have an internal defibrillator in your heart?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you have an artificial heart valve?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you have any aneurysm clips or metal clips in your body or head?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you have an implanted neurostimulator (TENS) units?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you have any type of biostimulator or bone growth stimulator? If yes, type:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you have any type of intravascular coil, filter or stent (i.e., Gianturco coil, Gunther IVC filter, Palmaz stent, etc.)?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you have any implanted orthopedic (bone) items i.e., pins, screws, nails, clips, plates, wires, or artificial limbs or joints?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you have an orbital or eye prosthesis?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you have any personal history of asthma, bronchitis, or emphysema?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you have a middle ear prosthesis, cochlear implant, or have you had ear surgery?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you have any known or possible metal fragments in the eye, head, or body? SPECIAL ATTENTION TO: Welding, metal grinding, machinists, and sheet metal workers)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Have you had a procedure within the past week where you swallowed a special "gastric capsule camera" that is used to look inside your stomach or intestines?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you have any type of implant held in place by a magnet (i.e., dentures)? If yes, what type:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you have a vascular access port?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you have any permanent tattoos, permanent eyeliner* or body piercing? (* A small percentage of patients with tattooed eyeliner have experienced transient skin irritation in association with MRI. You may want to discuss this matter with your imaging technologist.)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you have or are you wearing a hearing aid?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Are you claustrophobic?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you have a medication patch in place?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you have any personal history of cancer? If yes, what type?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you have any allergies? If yes, to what:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Are you diabetic? If yes, do you have an insulin pump?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you have any kidney disease? Yes or No If yes, are you on dialysis?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Have you ever had an injection of contrast (dye) for an MRI? If yes, did you have any type of reaction?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you have any other medical problems? (Please list):	<input type="checkbox"/> YES	<input type="checkbox"/> NO
For MRI Lumbar, Cervical, Thoracic. Have you had surgery on the area being scanned? If yes, add contrast	<input type="checkbox"/> YES	<input type="checkbox"/> NO
FEMALES ONLY:		
Are you pregnant?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Are you currently breast-feeding?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you have an inflatable breast implant or tissue expander implants?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you have an IUD in place?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
MALES ONLY:		
Do you have a penile prosthesis?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you have a tissue expander implant?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

For your information: As a routine part of your MRI exam, a contrast agent called "gadolinium" may be used to help enhance the areas being scanned. The most common side effects to this contrast agent are headache (less than 10%) and nausea (less than 5%).

I attest that the above information is correct to the best of my knowledge. I have read and understand the entire contents of this form and I have had the opportunity to ask questions regarding the information on this form.

Patient or Guardian Signature: _____ **Date:** ____/____/____

Revised 11-02-04 (F:Forms/CDI Metal Checklist.Patient)