SOLANO DIAGNOSTICS IMAGING

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MAGNETIC RESONANCE IMAGING (MRI)

PATIENT HISTORY AND SAFETY SCREENING

Name: _____ **MRN:**_____ **Date of Birth:**_____

Height_____ **Weight:** _____

	No	Yes
* Do you have a personal history of renal (kidney) disease?	❑	❑

	No	Yes
1. Have you ever had surgery to the area being scanned today?	❑	❑

If yes: Date: _____ Type of Surgery: _____

	No	Yes
2. Have you ever been diagnosed with Cancer of any type?	❑	❑

If yes: Date: _____ Type of Cancer: _____

	No	Yes
3. Have you had any prior diagnostic studies related to your current problem?	❑	❑

If yes:
- ❑ X-rays Date: _____ Place: _____
- ❑ CT Scan Date: _____ Place: _____
- ❑ Myelogram Date: _____ Place: _____
- ❑ MRI Scan Date: _____ Place: _____

	No	Yes
4. Are you presently working, or have you ever worked around machinery that produces metal particles or shavings, such as a metal lathe, metal grinder, metal drills, etc.?	❑	❑
If yes, have you had metal particles or shavings in your eyes?	❑	❑

5. The following conditions can interfere with MR Imaging, and some may be hazardous to the safety of the patient. Please review the following items very carefully and mark all appropriate boxes.

❑ Yes ❑ No Cardiac pacemaker		❑ Yes ❑ No Tattoos /Perm. Makeup	
❑ Yes ❑ No Brain or aneurysm clips		❑ Yes ❑ No Biostimulator	
❑ Yes ❑ No Venous "umbrella"		❑ Yes ❑ No Prosthesis	
❑ Yes ❑ No Ear implant(s)		❑ Yes ❑ No Metal mesh implants	
❑ Yes ❑ No Aortic clips		❑ Yes ❑ No Wire sutures	
❑ Yes ❑ No Metal fragments – in head, eyes, skin		❑ Yes ❑ No Shrapnel	
❑ Yes ❑ No Other metal implants (please explain)		❑ Yes ❑ No Dentures	
❑ Yes ❑ No Neurostimulator (TENS unit)		❑ Yes ❑ No Claustrophobia	
❑ Yes ❑ No Artificial heart valve		❑ Yes ❑ No Heart Stent	
❑ Yes ❑ No Insulin pump		❑ Yes ❑ No Pregnancy	
❑ Yes ❑ No Electrodes		❑ Yes ❑ No Difficulty breathing	
❑ Yes ❑ No Hearing aid			
❑ Yes ❑ No Intrauterine device (IUD)			
❑ Yes ❑ No Shunt, spinal or ventricular			
❑ Yes ❑ No Joint replacements			
❑ Yes ❑ No Metal plates, pins, screws, rods			

NOTE: If you are not sure if you have any of these conditions, please discuss any items in question with the technologist.

Explain as necessary: _____

ATTENTION: Some MRI exams require the use of IV contrast. The contrast used is gadolinium, a rare-earth metal which has little known contraindications. Please inform the technologist if you have had sensitivity to gadolinium in the past, if you have kidney problems or are pregnant or nursing. If you have any questions regarding contrast, please ask the technologist. Sign below to authorize use of contrast if needed for your exam and to certify that the above information is correct.

Signature of Patient: _____ **Signature of Technologist:** _____

Please Complete Second Page

What symptoms are you having related to today's exam? _____

_____

_____

How long have you had these symptoms? _____

_____

_____

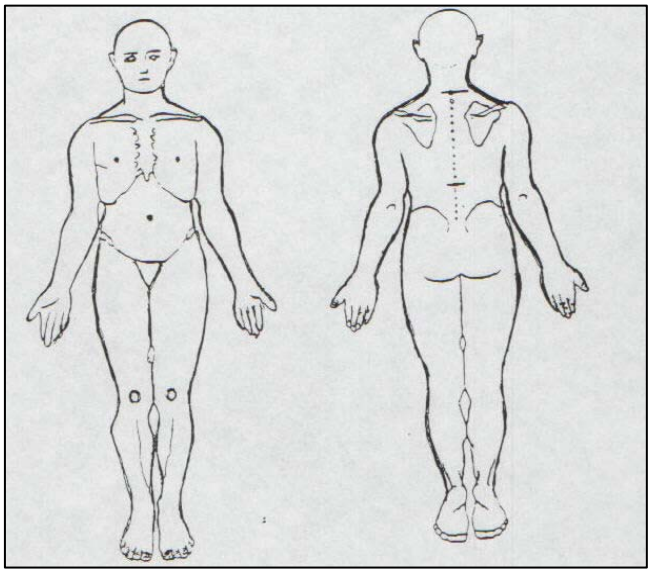
Spinal MRI Exam Questionnaire

CERVICAL SPINE

1. **Do you have neck pain?** ❑ **Yes** ❑ **No**
2. **Does this pain radiate into your arms?** ❑ **Yes** ❑ **No**
3. **If yes, which arm?** ❑ **Left** ❑ **Right** ❑ **Both**
4. **How far does the pain radiate into your arm(s)?** _____
5. **Is there any numbness associated with your pain?** ❑ **Yes** ❑ **No**
6. **If yes, please specify area(s) of numbness:** _____
7. **Do you have headaches associated with your pain?** ❑ **Yes** ❑ **No**

THORACIC OR LUMBAR SPINE

1. **Do you have low back pain?** ❑ **Yes** ❑ **No**
2. **Does this pain radiate into your legs?** ❑ **Yes** ❑ **No**
3. **If yes, which leg?** ❑ **Left** ❑ **Right** ❑ **Both**
4. **How far does the pain radiate into your leg(s)?** _____
5. **Is there any numbness associated with your pain?** ❑ **Yes** ❑ **No**
6. **If yes, please specify area(s) of numbness:** _____



Please Mark Areas Affected by Pain