Summit Imaging

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MRI / MRA EVALUATION
Patient History & Safety Screening

Name:_____ Date:_____ Date of Birth: _____

Referring Dr. _____ Weight: _____

Please answer all of the following questions:

☐ Yes ☐ No Do you have a cardiac pacemaker?

☐ Yes ☐ No Do you have aneurysm clips or prior brain surgery?

☐ Yes ☐ No Do you have any kind of implanted mechanical or electrical device (spine stimulator, cochlear implant, or insulin pump, etc.)?

☐ Yes ☐ No Do you have any metal plates, pins, screws, nails or clips? Where? _____

☐ Yes ☐ No Do you have on permanent eyeliner?

☐ Yes ☐ No Is there any possibility that you may be pregnant? LMP _____

☐ Yes ☐ No Do you have a history of metal in the eyes or head area or have you done work welding or grinding?

☐ Yes ☐ No Do you have a history of cancer?

☐ Yes ☐ No Have you ever had Radiation Therapy or Chemotherapy?

☐ Yes ☐ No Do you have bridgework, dentures, or hearing aids that are removable?

☐ Yes ☐ No Have you ever had a CT Scan or MRI of the area being examined today? If yes, when and where?

_____

☐ Yes ☐ No Have you ever had surgery of the area being examined? If yes, what type of surgery?_____

_____

☐ Yes ☐ No Have you ever had any vascular surgery or vascular stents placed? If yes, when and where? _____

_____

Signature of Patient: _____ Date: _____

Signature of Parent or Guardian: _____ Date: _____

Signature of Technician: _____ Date: _____

Technical Comments_____

_____

_____

_____

Please complete the area that is applicable to your exam.

MRI Brain Evaluation

☐ Yes ☐ No Dizziness/difficulty walking

☐ Yes ☐ No Visual disturbances

☐ Yes ☐ No Difficulty thinking, remembering

☐ Yes ☐ No Ringing in ears

☐ Yes ☐ No Loss of Hearing L/R

☐ Yes ☐ No Weakness in arms/legs

☐ Yes ☐ No Seizures

☐ Yes ☐ No Previous stroke

☐ Yes ☐ No History of cancer? If yes, list: _____

☐ Yes ☐ No Radiation treatment to the brain

☐ Yes ☐ No Previous brain surgery

☐ Yes ☐ No Other conditions: _____

Technical Comments: _____

MRI Musculoskeletal Evaluation

TMJ ____R ____L

Knee ____R ____L

Shoulder ____R ____L

Hips ____R ____L

Elbow ____R ____L

Ankle ____R ____L

Other Extremities ____R ____L

☐ Yes ☐ No Injury, Describe: _____

☐ Yes ☐ No Pain, Describe: _____

☐ Yes ☐ No Arthritis: _____

☐ Yes ☐ No Fracture/Dislocation: _____

☐ Yes ☐ No Previous Surgery/Arthroscopy (describe what was done): _____

Technical Comments: _____

MRI Spine Evaluation

Have you had any surgery? ☐ Yes ☐ No On which levels of the spine? _____

Where: _____ When: _____

Describe your pain: _____

List any other types of surgery: _____

Technical Comments: _____