

# CALF, TIB/FIB EVALUATION

Last Name:

First:

Date:

## THESE QUESTIONS APPLY ONLY TO THE AREA BEING SCANNED TODAY

1. Have you had an MRI or CT scan of this body part previously? Yes or No (circle one)

• If so, where and when?

2. What do you think is wrong? \_\_\_\_\_

3. Describe your symptoms:

4. What makes it better? \_\_\_\_\_

5. What makes it worse? \_\_\_\_\_

6. Do you have areas of weakness? Yes or No (Circle one) Weakness where? \_\_\_\_\_

7. Any surgery/arthroscopy on the scan area? Yes or No (Circle one) Date of surgery? \_\_\_\_\_  
What was done in surgery? \_\_\_\_\_

8. Do you have arthritis in any of your joints? Yes or No (Circle one) List joints: \_\_\_\_\_

9. Are you currently taking any medications? Yes or No (Circle one) List medications: \_\_\_\_\_

10. Do you have any other medical conditions? Yes or No (Circle one) List conditions: \_\_\_\_\_

11. List athletic activities that may have contributed to your condition: \_\_\_\_\_

12. Have you ever had cancer? Yes or No (Circle one) If yes, what type? \_\_\_\_\_

Have you undergone chemotherapy, radiation therapy or surgery for cancer? Yes or No (Circle one)  
If yes, what type of cancer treatment have you had? \_\_\_\_\_

Dates of cancer treatments: \_\_\_\_\_

13. Have you had an injury/trauma to the area being scanned today? (e.g. car accident, fall, etc.) Yes or No (Circle one) If yes, date of injury/trauma \_\_\_\_\_

14. Is there any other information about the area being scanned today that the radiologist should know about? \_\_\_\_\_

*Please fill out back of this form*



# California Advanced Imaging – Patient History, Safety Screening, and Consent Form

- Have you ever had metal fragments in your eyes? Yes  No
- Do you have any metal fragments in your body? Yes  No
- Do you have any prostheses? What type? \_\_\_\_\_ Yes  No
- Have you ever had spine surgery? Date \_\_\_\_\_ Yes  No
- Have you ever had heart surgery? Date \_\_\_\_\_ Yes  No
- Do you have a **pacemaker** or a **cardiac defibrillator**? Yes  No
- Do you have a surgically implanted heart valve? Yes  No
- Have you ever had brain surgery? Date \_\_\_\_\_ Yes  No
- Do you have brain (**aneurysm**) clips? Yes  No
- Have you ever had middle or inner ear surgery? Date \_\_\_\_\_ Yes  No
- Have you ever had eye surgery? Date \_\_\_\_\_ Yes  No
- Do you have an **insulin or medication pump**? Yes  No
- Do you wear dentures? Yes  No
- Do you wear **hearing aids?**(*Remove prior to MRI*) Yes  No
- Do you have on you any magnetically activated device? Yes  No
- Do you have any transdermal (medication patches) on you? Yes  No
- Do you have permanent make-up (eyeliner, etc.)? Yes  No
- Have you or are you using a “pillcam”/M2A endoscopy capsule? Yes  No
- **Females only:** Is there a chance that you might be pregnant? Yes  No

Print Name \_\_\_\_\_ Age \_\_\_\_\_ Weight \_\_\_\_\_

Patient signature \_\_\_\_\_ Date \_\_\_\_\_

Parent signature (if under 18 years old) \_\_\_\_\_

**Only answer the following questions if you are receiving an IV contrast injection:**

- Have you ever had MRI contrast? Yes  No
- Have you had any kind of reaction to contrast? Yes  No
- If yes please explain: \_\_\_\_\_
- Are you currently breast feeding? Yes  No
- Are you diabetic? Yes  No
- Do you have any history of hypertension (high blood pressure)? Yes  No
- Do you have any history of kidney (renal) insufficiency or failure? Yes  No
- Do you have a solitary kidney? Yes  No
- Are you on dialysis? Yes  No
- Do you have any liver disease? Yes  No
- Have you had or going to have a liver transplant? Yes  No