

CHEST/STERNUM/RIBS 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