SPINE EVALUATION

Last Name:	First:	Date:

<u>THESE QUESTIONS APPLY ONLY TO THE AREA BEING SCANNED TODAY</u>

1. Have you had an MRI or CT scan of this body part previously? Yes or No (circle one)
- If so, <u>where</u> and <u>when</u>?

____

2. What was your chief complaint when you visited your doctor?________________________________

____

3. What does your doctor think is causing your symptoms?____

4.How long have you had these symtoms?____

5. Do your symptoms involve your arm(s)? Yes or No (Circle one) If yes, LEFT, RIGHT or BOTH? (circle)
   Are the symptoms in your arm(s) in the FRONT, BACK or SIDE? (circle)

6. Do your symptoms involve your leg(s)? Yes or No (Circle one) If yes, LEFT, RIGHT or BOTH? (circle)
   Are the symptoms in your leg(s) in the FRONT, BACK or SIDE? (circle)

7. Do you have any numbness? Yes or No (Circle one) Where?________________________________

8. Do you have areas of weakness? Yes or No (Circle one) Where?_____________________________

9. Have you had any bowel or bladder changes? Yes or No (Circle one)

10. Any surgery/arthroscopy on your spine? Yes or No (Circle one) When? ____________________
    What was done in surgery? ____

11. 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:____

12. Do you have any other medical conditions? Yes or No (Circle one) List conditions:________________

____

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

- 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 □