THUMB/FINGER 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 □