MRI LOWER EXTREMITY
PATIENT HISTORY AND SCREENING

Name:_____ Referring Physician: _____

Please explain your present complaint or problem in detail_____

_____

Is this problem a result of an injury? ❑ No ❑ Yes
If so, how did it occur? _____
How long have you had this problem?_____
Previous injury or surgery to this area? ❑ No ❑ Yes When? _____

If yes, please explain what was done _____

_____

Please check if you have any of the following:

____ Lump or mass	____ Steroid therapy	____ Fever	____ Gout
____ Dislocation	____ Radiation therapy	____ Cancer	____ High BP
____ Numbness	____ Kidney disease	____ Diabetes	
____ Weakness	____ Liver disease		

If you checked anything listed above, please explain _____

_____

Does anything make the pain/condition worse? ❑ No ❑ Yes Explain _____

_____

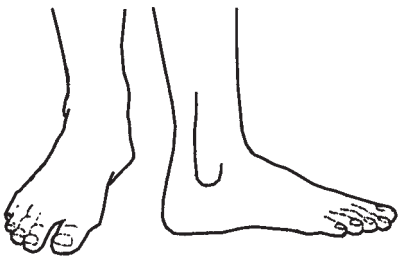
Does anything make the pain/condition better? ❑ No ❑ Yes Explain _____

_____

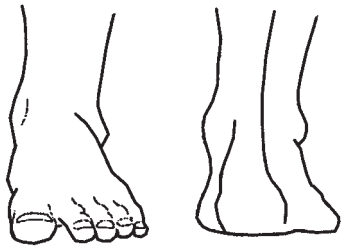
Have you had any previous exams of the body part being scanned today? ❑ No ❑ Yes
If yes, what type of exam? _____
When and where? _____

Please circle/shade the area where you are having problems on the picture below.

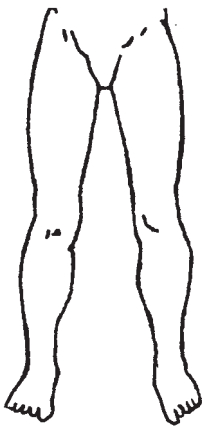
Right Foot



Left Foot



Right Left



(please turn over)

DIAGNOSTIC RADIOLOGY & IMAGING
we see you.

NAME:_____

DOB:_____

WEIGHT:_____**lbs.**_____

The following items may be harmful to you during your MRI Scan or may interfere with the MRI examination. You must provide a ''yes'' or ''no'' for every item. Please indicate if you have, or have had any of the following:

*** SIGNATURE:**	**YES**	**NO**
Any type of electronic, mechanical, or magnetic implant: eye, ear (otologic, cochlear, or other ear implant), penile, or other If yes, type: _____	☐	☐
Cardiac pacemaker	☐	☐
Aneurysm clip	☐	☐
Implanted cardiac defibrillator (ICD)	☐	☐
Neurostimulator / biostimulator (e.g., spinal cord or brain stimulator) If yes, type _____	☐	☐
Any type of internal electrodes or wires	☐	☐
Hearing aid	☐	☐
Implanted drug pump (e.g., insulin, baclofen, chemotherapy, pain medicine)	☐	☐
Halo vest	☐	☐
Spinal fixation device	☐	☐
Spinal fusion procedure	☐	☐
Any type of coil, filter, or stent If yes, where and what type? _____	☐	☐
Any type of metal object (e.g., shrapnel, bullet, BB, metal fragment, or foreign body)	☐	☐
Bone growth / bone fusion stimulator	☐	☐
Artificial heart valve	☐	☐
Eyelid spring	☐	☐
Any type of surgical clip or staple	☐	☐
Any IV access port (e.g., Broviac, Port-a-Cath, Hickman, PICC line)	☐	☐
Medication patch (e.g., nitroglycerin, nicotine)	☐	☐
Shunt (spinal or intraventricular)	☐	☐
Prosthesis (artificial limb, joint, or eye) If yes, location:_____	☐	☐
Tissue expander (e.g., breast)	☐	☐
Removable dentures, false teeth or partial plate	☐	☐
Diaphragm, IUD, pessary If yes, type: _____	☐	☐
Surgical mesh If yes, location _____	☐	☐
Body piercing, including dermal (under the skin) If yes, location _____	☐	☐
Permanent makeup (tattoos or tattooed eyeliner)	☐	☐
Radiation seeds (e.g., cancer treatment)	☐	☐
Bone / joint pins, rods, screws, nails, plates, wires, etc. If yes, location:_____	☐	☐
Tracking device (such as an ankle bracelet provided by law enforcement)	☐	☐

TECHNOLOGIST:_____

MRNOTE