

# Alpine Orthopaedic Medical Group, Inc.

## MRI Screening Questionnaire

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Date: \_\_\_\_\_

Sex: \_\_\_\_\_ Male \_\_\_\_\_ Female Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Weight: \_\_\_\_\_ Patient # \_\_\_\_\_

This questionnaire is designed to assist us in determining if it is safe for you to undergo a magnetic resonance imaging (MRI) procedure. It is important that you answer all of the following questions. If you don't understand a question, please ask for assistance. Circle the appropriate answer for each question.

- |     |   |     |    |
|-----|---|-----|----|
| 1.  | Do you have a pacemaker, wires, defibrillator, or implanted heart valves?   | Yes | No |
| 2.  | Have you ever had any head surgery?   | Yes | No |
| 3.  | Have you ever had any type of surgery?  | Yes | No |
| 4.  | Have you ever had a reaction to a contrast agent used for MRI, CT, or X-ray?  | Yes | No |
| 5.  | Do you have any surgically implanted metal of any type in your body?  | Yes | No |
| 6.  | Have you ever been exposed to metal fragments that could be lodged in your eyes or body?  | Yes | No |
| 7.  | Do you have a hearing aid, middle or inner ear prosthesis?  | Yes | No |
| 8.  | Do you have a metal pin, joint, prosthesis or metallic object in or attached to your body/  | Yes | No |
| 9.  | Do you have any type of electronic device (stimulator or pump) implanted in your body?  | Yes | No |
| 10. | Do you have or have you ever had tattoos, tattooed eyeliner, lip liner or a body piercing?  | Yes | No |
| 11. | Do you wear a transdermal patch (nitroglycerin or nicotine)?  | Yes | No |
| 12. | Do you have a history of panic attacks or a fear of enclosed or narrow places (Claustrophobia)?   | Yes | No |
| 13. | Do you have a history of drug or food allergies?  | Yes | No |
| 14. | Do you have a history of renal disease, seizure, asthma, or emphysema?  | Yes | No |
| 15. | Do you have any ocular or ophthalmologic implant (e.g. eye prosthesis)?   | Yes | No |
| 16. | Do you have dentures, partials, or other fixed dental implants?   | Yes | No |
| 17. | If you are a woman-are you pregnant, or is it possible that you might be pregnant?  | Yes | No |
| 18. | If you are a woman-are you breastfeeding?   | Yes | No |
| 19. | Is there any other item or device you believe we should know about prior to performing the procedure-<br>If Yes, please describe: _____ |     |    |

I certify that I have read and understand the questions asked in this questionnaire, and that the above responses are correct to the best of my knowledge. I understand that it is my responsibility to inform the center of any metallic bodies and/of devices that may be in my body, and that by failing to do so may cause serious bodily injury or may be life threatening. I agree that should I have any metal in my body and after consultation with a physician, I elect to proceed with the MRI, I agree to release Alpine Orthopaedic Medical Group, Inc. from any and all liability for any injury.

\_\_\_\_\_  
Patient or Legal Representative Signature

\_\_\_\_\_  
Print Name and Authority (Legal Representative)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness or Interpreter Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician/Registered Nurse/Technologist

\_\_\_\_\_  
Print Name and Title

\_\_\_\_\_  
Date

# Alpine Orthopaedic Medical Group, Inc. Patient Questionnaire

## Patient History Questionnaire

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Date: \_\_\_\_\_

Sex: \_\_\_\_\_ Male \_\_\_\_\_ Female Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Weight: \_\_\_\_\_ Patient Number: \_\_\_\_\_

## Reason for Procedure:

Please check any of the following symptoms that you are experiencing:

- Chest Pain     Headaches     Nausea     Hearing Loss     Abdominal Pain     Blackouts     Blurred Vision
- Ringing in Ears     Pelvic Pain     Dizziness     Memory Loss     Seizures     Back Pain     Neck Pain
- Unexpected Weight Loss     Shoulder Pain (  Right Side  Left Side)     Numbness (  Right side  Left side)     Leg Pain (  Right  Left)
- Weakness (  Right Side  Left Side)     Arm Pain (  Right Side  Left Side)    Other: \_\_\_\_\_

How and when did these symptoms occur (e.g., injury, just started, etc.)? \_\_\_\_\_

## Medical History:

1. Do you have or have you had any of the following?

- Cancer     Heart Disease     Kidney/Renal Disease     Multiple Myeloma     Hypertension (high blood pressure)
- Sickle Cell Anemia     Tumor, Lump or Mass     Bleed Easily or Hemophilia     Heart Arrhythmia     Diabetes     Seizures
- Congenital Heart Defect     Glaucoma     Stroke     Asthma, Bronchitis, or Emphysema     Chronic Obesity

Other Illness/Disease: \_\_\_\_\_

2. Have you had any tests (MRI, CT, X-Ray, etc.) performed for the symptoms you are currently experiencing?     Yes     No

If yes, please list the date, type and who had performed the test: \_\_\_\_\_

3. Have you had any surgeries or therapies (e.g., radiation therapy, chemotherapy, etc.)?     Yes     No

If yes, please list the date and type of surgery or therapy: \_\_\_\_\_

4. Are you currently taking any medications?     Yes     No

If yes, please list all medications you are currently taking: \_\_\_\_\_

5. Do you have any allergies (e.g., medications, latex, food, etc.)     Yes     No

If yes, please list all allergies: \_\_\_\_\_

I hereby certify that the above information is true and correct to the best of knowledge.

\_\_\_\_\_  
Patient or Legal Representative Signature

\_\_\_\_\_  
Print Name and Authority (if Legal Representative)

\_\_\_\_\_  
Date

Technologist Notes: \_\_\_\_\_