KENTUCKY ORTHOPAEDICS & SPINE

Name_____ Date_____

Date of Birth___ /___ /___ Age___ r Male r Female Weight: _____

Referring Physician_____Family Physician:_____

Reason for MRI and/or Symptoms_____

I. Have you ever had prior surgery/operation of any kind? I No I Yes
If yes, please indicate the date and type of surgery:
Date___ /___ /___ Type of surgery_____

Date___ /___ /___ Type of surgery_____

2. Have you had any study or examination related to today's MRI? No I Yes

If yes, please list:	Body part	Date	Facility
MRI	_____	___/___/___	_____
CT/Cat Scan	_____	___/___/___	_____
X-Ray	_____	___/___/___	_____
Ultrasound	_____	/ /	_____
Nuclear Medicine	_____	/ /	_____

3. Have you experienced any problem related to previous MRI? I No I Yes
If yes, please describe:_____

4. Have you had an injury to the eye involving a metallic object or fragment (metallic silvers, Shavings, foreign body, etc.)? I No I Yes
If yes, please describe:_____

5. Have you ever been injured by a metallic object or foreign body (BB, bullet, shrapnel, etc.)?
I No I Yes
If yes, please describe:_____

6. Are you currently taking or have you recently taken any medication or drug (including herbal supplements.? I No I Yes
If yes, please list:_____

7. Are you allergic to any medication? I No I Yes
If yes, please list:_____

8. Do you have a history of asthma, allergic reaction, respiratory disease, or reaction to a contrast medium? I No I Yes

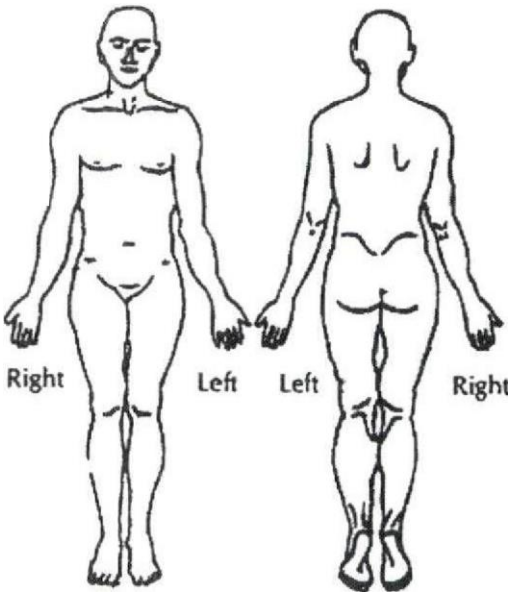
For female patients:

Date of last menstrual period:___ /___ /___ Post menopausal? I No I Yes
Are you pregnant or experiencing a late menstrual period? I No I Yes
Are you taking oral contraceptives or receiving hormonal treatment? I No I Yes
Are you taking any type of fertility medication or having fertility treatments? I No I Yes
If yes, please describe:_____
Are you currently breastfeeding? I No I Yes

Please answer all of following:

I' Yes D No Aneurysm clip(s)
[1Yes I I No Cardiac pacemaker
r Yes I l No Implanted cardioverter defibrillator (ICD)
r 1 Yes O No Electronic implant or device
n Yes I1 No Magnetically-activated implant device
ll Yes [7 No eurostimulation system
11 Yes LJ No Spinal cord stimulator
U Yes r· No Internal electrodes or wires
f, Yes Li No Bone growth/bone fusion stimulator
r I Yes I J No Cochlear, otologic, or other ear implant
r Yes r No Insulin or other infusion pump
I I Yes I I No Implanted drug infusion device
r' Yes l No Any type of prosthesis (eye, penile, etc.)
I• Yes I' No Heart valve prosthesis
I : Yes I I No Eyelid spring or wire
r: Yes I' No Artificial or prosthetic limb
l1 Yes 11 No Metallic stent, filter, or coil
11 Yes [l No Shunt (spinal or intraventricular)
r' Yes L No Vascular access port and/or catheter
LJ Yes Li No Radiation seeds or implants
I! Yes U No Swan-Ganz or thermodilution catheter
I , Yes I J No Medication patch (Nicotine, itroglycerine)
I I Yes l! No Any metallic fragment or foreign body
Ii Yes ,- No Wire mesh implant
I I Yes U No Tissue expander (e.g., breast)
,I Yes (7 No Surgical staples, clips, or metallic sutures
r Yes fi No Joint replacement (hip, knee, etc.)
r Yes ,I No Bone/Joint pin, screw, nail, wire, plate etc.
r 1 Yes I; No IUD, diaphragm, or pessary
I Yes I No Dentures or partial plates
I Yes I ; No Tattoo or pennanent makeup
I Yes I• No Body piercing jewelry
f. Yes l No Hearing aid **(Remove before entering MRI system room)**
I Yes I i No Other implant_____
(Yes 11 No Breathing problem or motion disorder
1-, Yes n No Claustrophobia

Please mark on the figure(s) below the location of any implants or metal inside **of or** on your body.



Pica.st contact the MRI Technologist or Radiologist if you **b■ve** any questions or concerns BEFORE you enter the M.RJ system room.

I attest that the above information is correct to the best ofmy knowledge. I have read and understand the entire contents of this form and have had the opportunity to ask questions regarding the information on this form and regarding the MR procedure that I am about to undergo.

Signature of Person Completing fonn:_____Date___ /___ /___

Form completed by: Patient Relative Nurse _ _ _ _ _ _ _ _ _ _ _ _ _ _ _
Print ame Relationship to patient

Form information Reviewed By:_____ _____
Print n111T1e Signature ignatun:

MRl Technologist Radiologist I Other_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Patient was informed of their rights to alternative imaging facilities.