Colorado Canyons
HOSPITAL & MEDICAL CENTER

Services provided by Family Health West

300 W Ottley Ave • Fruita CO 81521 • 970.858.2149

PATIENT DATA

MRI PATIENT HISTORY & ASSESSMENT

X-020

What problems brought you to the doctor that resulted in this exam being ordered? _____

What do you think might have caused the problem and when did the problem start? _____

_____

Have you had any previous surgery on the part of your body that we are scanning today? ❑ Yes ❑ No

Please list all the surgeries you have had and the dates:

DATE	**TYPE OF SURGERY**
_____	_____
_____	_____
_____	_____

Have you had a prior diagnostic imaging study or examination (MRI, CT, Ultrasound, X-Ray, etc.) of the body part to be examined?
❑ Yes ❑ No If yes, please list:

	Month / Year	Facility
MRI _____	_____	_____
CT/CAT Scan _____	_____	_____
X-Ray _____	_____	_____
Ultrasound _____	_____	_____
Nuclear Medicine _____	_____	_____
Other _____	_____	_____

If you have had any other TREATMENTS (including radiation or chemotherapy) involving the part of your body that we are examining today, please list them _____

Please circle area of pain and/or discomfort on the drawing below. Draw arrows if pain extends from one area to another. Also indicate SYMPTOMS using the following capital letters: **D**=dull ache **S**=sharp pain **N**=numbness T=tingling

DEPARTMENT USE ONLY

Lot #_____ Exp.Date _____

_____

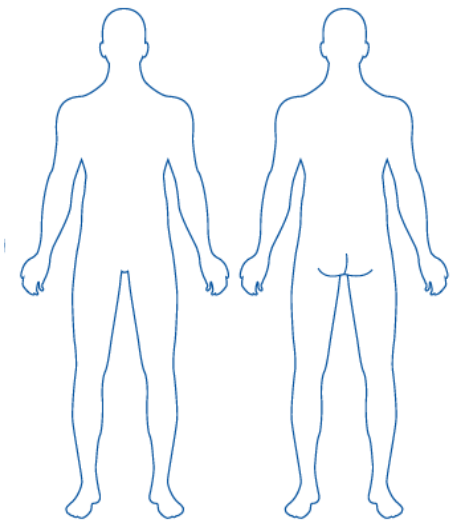
_____

_____

_____

_____

_____ _____ _____
Signature Date Time



Right **Right**

The following questions are being asked to ensure your safety and to make us aware of any conditions that could interfere with your MRI. Please answer all questions and provide detailed explanations wherever necessary.

WARNING: Certain implants, devices or objects may be hazardous to you and/or may interfere with the MR procedure (i.e., MRI, MR, angiography, functional MRI, MR spectroscopy). **Do not enter** the MR system room or MR environment if you have any question or concern regarding an implant, device or object. Consult the MRI Technologist or Radiologist BEFORE entering the MR system room. **The MR system magnet is ALWAYS on.**

Please indicate if you have any of the following

Yes	No	Aneurysm clip in the brain	Yes	No	Artificial heart valve replacement
Yes	No	Cardiac (heart) pacemaker or wires	Yes	No	Rods, plates, screws or nails in bone
Yes	No	Implanted heart defibrillator	Yes	No	Joint replacement
Yes	No	Neurostimulator	Yes	No	Surgical vascular clips (other than brain)
Yes	No	Cochlear or stapes implant	Yes	No	Magnetic eye implant / eyelid sping
Yes	No	Insulin or other medication pump	Yes	No	Retinal tack
Yes	No	Dental magnet	Yes	No	Heart stent
Yes	No	Bullets, BBs, pellets or shrapnel	Yes	No	Patches used to apply medications
Yes	No	Swan-Ganz or thermodilution catheter	Yes	No	Removable dental work
Yes	No	Abdominal aortic graft stent	Yes	No	Hearing aids

List any other implanted device_____

Yes No Have you done work involving welding or grinding of ANY metal?
Yes No Have you ever been hit in the face with metal fragments or slivers?

Please answer yes or no to the following questions. Do you have:

Yes	No	Diabetes	Yes	No	Reaction to any radiographic contrast
Yes	No	Sickle cell anemia	Yes	No	Dialysis or kidney problems
Yes	No	High blood pressure	Yes	No	Current or past history of cancer
					If yes, what kind? _____

For female patients:

Yes No **Are you pregnant or experiencing a late menstrual period?**
Date of last menstrual period was ____/____/____
Yes No Post menopausal?
Yes No Are you taking oral contraceptives or receiving hormonal treatments?
Yes No Are you currently breast feeding?

DO NOT BRING ANYTHING INTO THE SCAN ROOM WITH YOU. Some items, if brought into a magnetic field could pose harm, could damage the equipment, and could also themselves be damaged or destroyed.

I have read and I understand this safety questionnaire and I certify that all the information is true and accurate to the best of my knowledge.

Printed Name _____ Weight_____

Signature_____ Today's Date _____

Tech Signature _____