WASHINGTON ORTHOPAEDIC CENTER

Basic Medical Information for Orthopaedic Problems:

Please fill out this form to the best of your ability. If you do not know exact dates, just estimate. This information is very important and will be reviewed during the interpretation of your MRI.

Last Name:_____ First Name:_____

Age:_____ Date of Birth:_____

Dominant Hand:_____ Height:_____ Weight:_____ Gender: M / F

Occupation:_____ Employer:_____

Work Related?_____ Auto Related?_____ Date of Accident:_____

Questions	Please Write Answers Below
What problem are we evaluating today?	
When did this problem first occur?	
Was this problem a result of an accident, or repetitive stress? If accident, what is the date of injury?	
Where is the pain/problem located exactly? (example: front/back, inside/outside of joint) Does the pain radiate anywhere?	
If you have pain, please describe it and rate from a scale of 0-10, with 0 meaning "no pain" and 10 meaning "worst ever".	
What relieves the symptoms?	
Have you had a similar problem before? When?	
What medical imaging tests or treatments have you had for the problem?	
Have you had arthroscopy or surgery before? Please list.	
What other medical conditions do you have? (example: cancer, anemia, and osteoporosis)	

MRI Pre-Entry Screening

Pacemaker, pacer wires and/or implanted cardiac defibrillator? _____YES/NO
If YES, notify us immediately.
Brain aneurysm clips? **If YES, notify us immediately.**_____YES/NO
Have you ever had an MRI scan before? Body part:_____Date:_____YES/NO
Have you ever had surgery on the area to be scanned?_____YES/NO
Procedure:_____Date:_____
Have you *EVER* had a metal injury to your eyes? _____YES/NO
If yes, please notify us immediately.
Have you had an MRI since the incident of metal to your eyes?_____YES/NO
Are you clinically claustrophobic?_____YES/NO
Do you have a history of cancer?_____YES/NO
Do you have any major medical problems? Please list._____YES/NO
Are you pregnant or could you be pregnant? _____YES/NO
If yes, please notify us immediately.

Please Circle The Appropriate Response:

Neuro-stimulator?_____Y/N
Bone growth stimulator?_____Y/N
Joint replacements?_____Y/N
Other metal (rods, shrapnel,
Screws, bullets)?_____Y/N
Wires/sutures/clips?_____Y/N
Eye prosthesis?_____Y/N
Inner ear implants (cochlear,
Stapes)?_____Y/N
Insulin pump?_____Y/N
Morphine pump?_____Y/N
Magnetic dental implant?_____Y/N

Heart valve?_____Y/N
Greenfield filter?_____Y/N
Vascular stent?_____Y/N
Penile implant?_____Y/N
Tattoos?_____Y/N
Tattooed eyeliner?_____Y/N
Hearing Aids?_____Y/N
Harrington rods?_____Y/N
Electronic device?_____Y/N
Infusion pump?_____Y/N
Chemo pump?_____Y/N
Removable denture work?_____Y/N

Notes from the Technologist

Please Read Prior to Signing

You must remove all metallic objects including: easily removable jewelry, bras, shoes, belts, hair pins, safety pins, paperclips, money clips, coins, pens, watch, etc. If you have any body piercings (other than ears) please let the Technologist know. Your signature on this form indicates that you authorize and consent to the performance of this procedure.

Patient Signature or Representative (if minor) Date

MRI Technologist Date