WASHINGTON OPENMRI

Patient History Questionnaire

Patient Name:______________________________________ Date of Birth:_______________

Sex: MALE FEMALE Weight:__________ Symptoms:_____________________________

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Where is the pain located?__________________________ Date of injury or onset of pain:_________

Have you had surgery on the area being scanned? YES NO When? _____________________

Do you have any other medical problems?____

If so, have/are you receiving treatment? YES NO Describe treatment:_____________________

____

Is this related to an on-the-job injury or auto accident? YES NO

Fully complete the following by checking either Y (Yes) or N (No):

Y	N	
		Cardiac Pacemaker/Pacemaker Lead Wires *
		Implanted Cardiac Defibrillator *
		Brain Aneurysm Clips *
		Neurostimulator
		Cardiac Stent
		Spinal Fusion Stimulator
		Implant held in place by a magnet
		Tissue Expander
		Cochlear, Otologic, or Ear Implant
		Metal Slivers in Eyes
		Have you ever been a machinist or metal worker?
		Have you ever had a facial injury from metal?
		Have you ever had metal removed from your eyes?
		Carotid Artery Vascular clamp
		Aortic Clips
		Artificial Heart Valves
		Venous Umbrella
		Insulin or Drug Infusion Pump
		Coil, Filter, Stent or Wire in Blood Vessel
		Pessary or Bladder Ring
		Shunt (Spinal or Intraventricular)
		Tens Units
		Prosthesis (Eye/Orbital, Penile, etc.)
		Shrapnel or Prior Gunshot Wound

Y	N	
		Transdermal Medication Patch (Nitro)
		Electrodes (on Body, Head or Brain)
		Artificial Limbs
		Hearing Aid (REMOVE BEFORE SCAN)
		Dentures or Partials
		IUD or Diaphragm
		Vascular Access Port or Catheter
		Swan-Ganz Catheter
		Fractured bones treated with metal rods, plates, pins, screws, nails or clips
		Harrington Rods (Spine)
		Metal or Wire Mesh Implants
		Wire Sutures or Surgical Staples
		Tattoo (Eyeliner, Eyebrow or Other)
		Body Piercing
		Are you pregnant, possibly pregnant or breast feeding?
		History of Sickle Cell Anemia
		Drug Allergies
		Renal Disease
		Currently on Dialysis
		Liver Disease
		History of Cancer

If Yes, Where/When: ____________________

** CANNOT BE SCANNED*

Women Only - Date of last menstrual cycle: ________________

______________________________ ________________

Patient Signature ***Date***

Technologist Notes Only

Tech Name: ____________

Contrast : ____________ CCs

# of Series: ____________

Priors: Y N

-----Please inform the MRI Technologist if you are pregnant-----