aspen
ORTHOPEDIC SPECIALISTS
Experience. Excellence.

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Brookfield PT – 2205 N. Calhoun Road, #17
New Berlin - 12555 W. National Avenue, Suite 100
Oak Creek - 8907 S. Howell Ave #800

www.aspenors.com

Date:_____

MRI HISTORY FORM

Patient Name: _____

DOB: _____

Current Height & Weight: _____

Claustrophobic? ☐ Yes ☐ No

Sedation Needed? ☐ Yes ☐ No

Appointment date & time: _____

Ordering physician: _____

Type of Exam: _____

Diagnosis:_____

_____

History and MRI Safety Screening Questions

☐ Yes ☐ No Cardiac Pacemaker or Defibrillator
☐ Yes ☐ No Aneurysm Clips
☐ Yes ☐ No Cochlear Implant/Stapedectomy
☐ Yes ☐ No Insulin Pump
☐ Yes ☐ No Acute GI Bleed/Endoscopy clips placed
☐ Yes ☐ No Deep Brain Neurostimulators
☐ Yes ☐ No ANY SURGERY in past 6 weeks (date) _____
If YES, stop! Op Note, MRI report or implant card is needed!

☐ Yes ☐ No Do you currently or have you EVER worked with metal? (grinding, welding or any other metal work)
☐ Yes ☐ No Have you had an injury to your eye involving a metallic object? (e.g. metallic slivers, foreign body, etc.)
☐ Yes ☐ No Orbit x-ray required? _____

☐ Yes ☐ No Have you had any surgery of any kind?
If yes, type of surgery: _____
☐ Yes ☐ No Have you ever been diagnosed with cancer?
☐ Yes ☐ No Have you ever had chemotherapy or radiation?
☐ Yes ☐ No Are you pregnant, possibly pregnant or nursing?
☐ Yes ☐ No Do you have any allergies to food, medicine or latex?
☐ Yes ☐ No Have you ever had an allergic reaction to contrast dye?
If yes, type of reaction: _____

Technologist's History: _____
_____
_____
_____
_____
_____
_____
_____

Initials: _____ Date: _____

☐ Yes ☐ No Pacemaker, wires or defibrillator
☐ Yes ☐ No Brain aneurysm clip
☐ Yes ☐ No Ear or eye implant
☐ Yes ☐ No Hearing Aide
☐ Yes ☐ No Electrical stimulator for nerves/bone (TENS)
☐ Yes ☐ No Bullets, BBs, pellets or shrapnel
☐ Yes ☐ No Magnetic implant anywhere
☐ Yes ☐ No Infusion pump
☐ Yes ☐ No Coil/filter/wire or stent in blood vessel
☐ Yes ☐ No Artificial limb or joint
☐ Yes ☐ No Tattoo
☐ Yes ☐ No Implanted catheter or tube
☐ Yes ☐ No Artificial heart valve
☐ Yes ☐ No Penile prosthesis
☐ Yes ☐ No Shunt
☐ Yes ☐ No False teeth, or removable bridges
☐ Yes ☐ No Braces, dental work (except fillings)
☐ Yes ☐ No Diaphragm or IUD
☐ Yes ☐ No Surgical clips, staples, wires or mesh
☐ Yes ☐ No Orthopedic plates, screws, pins, rods, wires
☐ Yes ☐ No Body piercings
☐ Yes ☐ No Nicotine/Nitroglycerine/Pain/HRT-hormone patch

If ordered with IV contrast:
☐ Yes ☐ No Any history of renal disease, including: solitary kidney, renal transplant, renal neoplasm, renal failure, dialysis or Nephrogenic Systemic Fibrosis/Nephrogenic Fibrosing Dermopathy (NSF/NFD)
☐ Yes ☐ No Any history of HTN (hypertension), DM (diabetes), severe liver disease, including liver transplant
☐ Yes ☐ No Is patient 60 years or older?
☐ Yes ☐ No Obtain Gadolinium Creatinine/eGFR

Aspen Interviewer's Signature: _____ Date: _____

Patient's Signature: _____ Date: _____

YOU MUST PRINT THIS FORM OUT AND BRING IT WITH YOU TO YOUR APPOINTMENT.
THIS FORM DOES NOT AUTOMATICALLY GET SENT TO ASPEN.
IF YOU DO NOT PRINT THIS FORM OUT, THE INFORMATION WILL BE LOST.