ASPEN Orthopedics
www.aspenors.com

Phone - **262/395-4141**

Brookfield - 19475 W. North Avenue, Suite 201
New Berlin - 12555 W. National Avenue, Suite 100
Pewaukee - 2900 Golf Road, Third Floor

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 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: _____

PRINT CLEAR