Coastal Orthopedics - MRI Procedure History Form

Date _____/_____/_____ Male ☐ Female ☐ Date of Birth _____/_____/_____

Name ____ Age ________ Height ________ Weight ________

Body Part Being Examined ____ #

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1. **Have you had prior surgery or an operation (e.g., arthroscopy, endoscopy, etc.) of any kind?** ☐ **Yes** ☐ **No** #
   If yes, please indicate the date and type of surgery:
   Date _____/_____/_____ Type of surgery ____ #
   Date _____/_____/_____ Type of surgery ____
   Date _____/_____/_____ Type of surgery ____ ##
2. **Have you had a prior diagnostic imaging study or examination related to the area we are scanning?** ☐ **Yes** ☐ **No**
   If yes, please list:

	Body part	Date	Facility
MRI		_____/_____/_____	
CT/CAT Scan		_____/_____/_____	
X-Ray		_____/_____/_____	

3. **Have you experienced any problems related to a previous MR examination or MR procedure?** ☐ **Yes** ☐ **No**
   If yes, please describe: ____
4. **Have you had an injury to the eye involving a metallic object or fragment (e.g., metallic slivers, shavings, foreign body, etc.)?** ☐ **Yes** ☐ **No**
   If yes, please describe: ____
5. **Have you ever been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel, etc.)?** ☐ **Yes** ☐ **No**
   If yes, please describe: ____

For female patients:

6. **Date of last menstrual period:_____/_____/_____ Post menopausal?** ☐ **Yes** ☐ **No**
7. **Are you pregnant or experiencing a late menstrual period?** ☐ **Yes** ☐ **No**

**************************************OPTIONAL SECTION*************************************

If you require a copy of your image(s) today, please complete the section below:

AUTHORIZATION FOR DISCLOSURE OF MRI HEALTH INFORMATION

I hereby authorize **COASTAL ORTHOPEDICS** to dispense my MRI health information to (**Patient/Guardian Name**): ____

Send a copy of the MRI and report digitally (free of charge); email address required: _________________________

Or pay $15.00 today and receive the MRI on CD (may take up to 45mins). **MRI-Report will be sent via standard mail** (may take up to 14 business days).

Address: ____City: _______________________ State: _____ Zip: ___________
Telephone: ___________________________

This authorization is for the **MRI only**. I understand that I need not sign this authorization in order to ensure health care treatment, payment, enrollment in my health plan, or eligibility for benefits.
Costs of Reproducing Medical Records Fl Statue 64B8-10.003

By signing, you are acknowledging that fees incurred by producing a copy of your medical records is your responsibility and will be applied to your account. Payment is due at time of pickup.

____ _______________
Signature of Patient/Authorized Representative (include relationship or nature of authority) Date

Coastal Orthopedics, Medical Records Department

Office Use Only

Trauma/Injury: ☐ No ☐ Yes ____
History of CA: ☐ No ☐ Yes ____
History of SX: ☐ No ☐ Yes ____
Relevant Priors: ☐ No ☐ Yes ____#