Coastal Orthopedics & Sports Medicine - MRI Procedure History Form

Date _____/_____/_____ **Date of Follow Up Appt** _______________

Name ____ **Age** ________ **Height** ________ **Weight** ________

Last name First name Middle Initial

Date of Birth _____/_____/_____ **Male** ☐ **Female** ☐ **Body Part to be Examined** ________________________

month day year

Reason for MRI and/or Symptoms ____

Referring Physician __________________________________

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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	________________________	_____/_____/_____	___________________________________
Ultrasound	________________________	_____/_____/_____	___________________________________
Nuclear Medicine	________________________	_____/_____/_____	___________________________________
Other__________	________________________	_____/_____/_____	___________________________________

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

Office Use Only

☐ Wet Read Contact Name: ___________________________
☐ STAT Report Contact Number: _________________________
☐ ASAP
Symptoms:
Duration:
Trauma/Injury: ☐ No ☐ Yes ____________________________
History of CA: ☐ No ☐ Yes ____________________________
History of SX: ☐ No ☐ Yes ____________________________
Relevant Priors: ☐ No ☐ Yes ____________________________
Additional Tech Notes: