RADIOLOGY & MRI
of Bethlehem, Inc.

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MRI Evaluation Sheet

Patient Name ______________________________

Age ____________________ Date ____________________

DO YOU HAVE ANY OF THE FOLLOWING IN/ON YOUR BODY?

Insulin Pump	Yes ____	No ____	Braces	Yes ____	No ____
Harrington Rods	Yes ____	No ____	Clips/Plates - Brain Surgery	Yes ____	No ____
Shrapnel	Yes ____	No ____	Valves/Implants – Heart	Yes ____	No ____
Tens Unit	Yes ____	No ____	Artificial Limbs (Prosthesis)	Yes ____	No ____
Tattoos	Yes ____	No ____	Body/Tongue Piercing	Yes ____	No ____
Hearing Aid	Yes ____	No ____	Clips from Vascular Surgery	Yes ____	No ____

1. Do you have any history of cancer? Yes ____ No ____
   Type ____________________ Treatment ____________________
   ____
2. Have you ever been a metal worker? Yes ____ No ____
3. Did you ever get metal fragments in your eyes or any other part of your body?
   Yes ____ No ____ If yes, where? ____________________
   Was it removed? Yes ____ No ____
4. If female, is there any chance of pregnancy? Yes ____ No ____
5. What was your chief complaint when you visited your doctor?
   ____
6. What do you think it is caused by? ____________________
7. How long have you had your symptoms? ____________________

8. Have you had any surgery to the area being scanned today? Yes ____ No ____
   When? ____
   What was done? ____

9. Do you have any other medical conditions? Yes ____ No ____
   If yes please explain ____

10. Have you had any previous studies on the area being scanned today? Yes ____ No ____
   When? ____
   Where? ____

PATIENTS FOR MRI OF THE SPINE – PLEASE COMPLETE THIS SECTION

Does the pain go down your leg? Yes ____ No ____

Does the pain go down your arm? Yes ____ No ____

In the back or front? Yes ____ No ____

Left or right or both? Yes ____ No ____

I hereby acknowledge that the above information is correct and accurate to the best of my knowledge.

Patient Signature ____ Date __________________

Parent/Guardian Signature _____________________________________ Date __________________