Patient History Questionnaire (MRI)

Ventura Orthopedics

☐ 2221 Wankel Way | Oxnard | CA 93030
P 805.988.9366 | F 805.483.3747

☐ 2525 Erringer Road | Simi Valley | CA 93065
P 805.527.1404 | F 805.527.5246

Patient Name_____ Date _____

Referring Doctor _____DOB _____Sex _____Weight _____

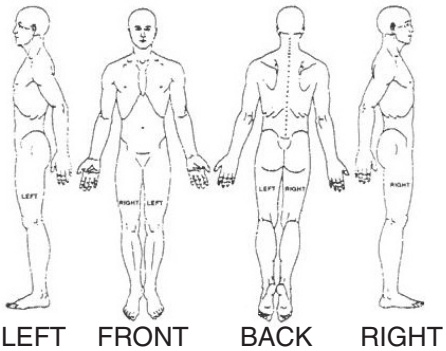
This questionnaire is designed to assist us in determining if it is safe for you to undergo a magnetic resonance imaging procedure. It is important that you answer all of the following questions **on both sides**. If you don't understand any question, please ask for assistance.

Reason for Procedure

Please check any of the following symptoms that you are experiencing:

☐ Chest Pain ☐ Headaches ☐ Nausea ☐ Hearing Loss
☐ Seizures ☐ Blackouts ☐ Blurred Vision ☐ Ringing in Ears
☐ Pelvic Pain ☐ Dizziness ☐ Memory Loss ☐ Abdominal Pain
☐ Back Pain ☐ Neck Pain ☐ Unexpected Weight Loss
☐ Shoulder Pain (☐ Right / ☐ Left) ☐ Arm Numbness (☐ Right / ☐ Left)
☐ Arm Pain (☐ Right / ☐ Left) ☐ Arm Weakness (☐ Right / ☐ Left)
☐ Leg Numbness (☐ Right / ☐ Left) ☐ Leg Pain (☐ Right / ☐ Left)
☐ Leg Weakness (☐ Right / ☐ Left) ☐ Hip Pain (☐ Right / ☐ Left)

☐ Other: _____



Please identify the location of any pain/numbness/lump

Reason you are here today? Please explain your medical problem in detail ...

What is the problem? How long have you had this problem?

_____

_____

Is your problem related to an injury? ☐ Yes ☐ No If yes, date of the injury: _____

How injured? ☐ MVA ☐ Work ☐ Other (please explain) _____

Medical History

1. Do you have or have had any of the following?

☐ Cancer, Type _____ ☐ Heart Disease ☐ Kidney/Renal Disease ☐ Multiple Myeloma ☐ Hypertension
☐ Multiple Sclerosis ☐ Seizures ☐ Sickle Cell Anemia ☐ Tumor, Lump, Mass ☐ Bleeding Tendency
☐ Heart Arrhythmia ☐ Diabetes ☐ Congenital Heart Defect ☐ Glaucoma ☐ Stroke

☐ **Previous Spine Surgery, Date:** _____ **Type of Surgery/Level** _____
☐ Asthma, Bronchitis or Emphysema ☐ Other Illness/Disease

2. Have you had any tests (MRI, CT, X-ray, etc.) performed for the symptoms you are currently experiencing or on the body part being scanned today? ☐ Yes ☐ No If yes, please list the date, type and where the test was performed:

_____

3. Have you had any surgeries or therapies (e.g., radiation therapy, chemotherapy, etc.)? ☐ Yes ☐ No If yes, please list the date and type of surgery or therapy: _____

4. Are you currently taking any medications? ☐ Yes ☐ No If yes, please list all the medications you are currently taking:

_____

5. Do you have any allergies (e.g., medication, latex, food, etc.)? ☐ Yes ☐ No If yes, please list allergies:

_____

Ventura Orthopedics

Patient History Questionnaire (MRI)

Please indicate if you have had any of the following:

1.	Do you have a pacemaker, wires, defibrillator, or implanted heart valves?	☐ Yes	☐ No
2.	Have you ever had any brain surgery requiring aneurysm clips?	☐ Yes	☐ No
3.	Have you ever had a reaction to a contrast agent used for MRI, CT or X-ray?	☐ Yes	☐ No
4.	Do you have any surgically implanted material of any type in your body?	☐ Yes	☐ No
5.	Have you ever been exposed to metal fragments that could be in your eyes an/or body?	☐ Yes	☐ No
6.	Do you have a hearing aid, middle/inner ear prosthesis, stent or dentures?	☐ Yes	☐ No
7.	Do you have any type of electrical device (stimulator or pump) implanted in your body?	☐ Yes	☐ No
8.	Do you have any metal pin, joint, prosthesis or metallic object in, or attached to your body?	☐ Yes	☐ No
9.	Do you have or have you ever had tattoos, tattooed eyeliner or lipliner or body piercing?	☐ Yes	☐ No
10.	Do you wear a transdermal patch (nitroglycerin or nicotine)?	☐ Yes	☐ No
11.	Do you have a history of panic attacks or a fear of enclosed or narrow places? Are you claustrophobic?	☐ Yes	☐ No
12.	Do you have a history of renal disease, seizure, asthma, emphysema?	☐ Yes	☐ No
13.	If you are a woman, are you pregnant, or is it a possibility that you might be pregnant?	☐ Yes	☐ No
14.	If you are a woman, are you breast feeding?	☐ Yes	☐ No
15.	Is there any other item or device you believe we should know about prior to performing the procedure?	☐ Yes	☐ No

If yes, please describe: _____

I certify that I have read and understood the questions asked in the questionnaire and that the above responses are correct to the best of my knowledge. I understand that it is my responsibility to inform Ventura Orthopedics Medical Group, Inc. of any metal fragments and/or devices that may be in my body and that by failing to do so may cause serious bodily injury or be life threatening. I agree that should I have any metal in my body and, after consultation with a physician, elect to proceed with the MRI, I agree to release Ventura Orthopedics Medical Group, Inc. from any and all liability for any injury.

Assignment and Release

I hereby authorize payment to be made directly to Ventura Orthopedics Medical Group, Inc. LLC, and fully understand that I am the responsible party for all medical bills incurred by me at the above mentioned facility. I also authorize release of any information required for the processing of this claim. If a legal action becomes necessary to enforce payment, I agree to pay a reasonable attorney fee.

I hereby authorize Ventura Orthopedics Medical Group, Inc. to disclose when treated by the above named insurance carrier or its representatives, transmissions of portions of patient's medical records to Physicians Data Corporation for electronic storage and retrieval, any and all information with respect to any illness(es), or injury(ies), medical history of treatment and copies of all medical records. A photostatic copy of this authorization shall be considered effective and valid as the original.

_____	_____	_____
Patient or Legal Representative Signature	Print Name and Authority (if Legal Representative)	Date
_____	_____	_____
Witness or Interpreter Signature	Print Name	Date
_____	_____	_____
Physician/Registered Nurse/Technologist	Print Name and Title	Date

Technologist Notes: _____

_____

_____

_____

_____