NEWPORT ORTHOPEDIC INSTITUTE

22 Corporate Plaza Drive
Newport Beach, CA 92660
MRI: (949) 722-5001
First Floor Suite 101

APPOINTMENT
Date:_____
Time:_____

Last Name:_____ First Name:_____ M.I:_____ Age:_____ Sex: M / F

DOB:_____ Height:_____ Weight:_____ Dominant Hand: Right / Left

Date of Injury:_____ Referring Physician:_____ Occupation:_____

Do you have any of the following? (Please circle *YES* or *NO*):

- Pacemaker, pacer wires and/or implanted defibrillator (AICD)? **If yes, please notify us immediately!** ------- Y / N
- Brain aneurysm clip? **If yes, please notify us immediately!** ---------- Y / N
- Are you pregnant or could be pregnant? **If yes, please notify us immediately!** ---------- Y / N
- Have you had an MRI scan on the body part that is being scanned today? ---------- Y / N
  - If yes, date of MRI ___ /___ /___
- Have you ever had surgery on the body part that is being scanned today? ---------- Y / N
  - If yes, date of surgery ___ /___ /___ Procedure:_____
- Have you EVER had a metal injury to your eyes? ---------- Y / N
  - If yes, have you had an MRI since the incident of metal to your eyes? ---------- Y / N
- History of metal grinding or welding? ---------- Y / N
- Do you have a personal history of cancer? ---------- Y / N
  - If yes, please indicate the type of cancer:_____
- Do you have any major medical problems? ---------- Y / N
  - If yes, please list:_____

Do you have any of the following devices implanted? (Please circle *YES* or *NO*):

* Bone growth or Neuro-stimulator	Y / N	* Greenfield filter	Y / N	* Hearing aids	Y / N
* Heart Valve or monitor	Y / N	*Glucose monitor	Y / N	*Hair extensions	Y / N
* Joint replacements	Y / N	*Pumps (**insulin**, infusion, morphine, or chemo)	Y / N	* Tattoos (including cosmetic)	Y / N
* Any metal (shrapnel, screws, bullets, wires, sutures, or clips)	Y / N	*Vascular stent	Y / N	* Prosthetics	Y / N
* Internal electronic device	Y / N	*Shunt	Y / N	* Removable dentures	Y / N
* Harrington rods	Y / N	* Inner ear implants (cochlear, stapes)	Y / N	* Penile implant	Y / N

How did the problem first occur? (Example: recent method of injury, chronic condition, unsure etc.)

_____

Where exactly is the problem located? (Example: front, back, inside, outside, etc.)

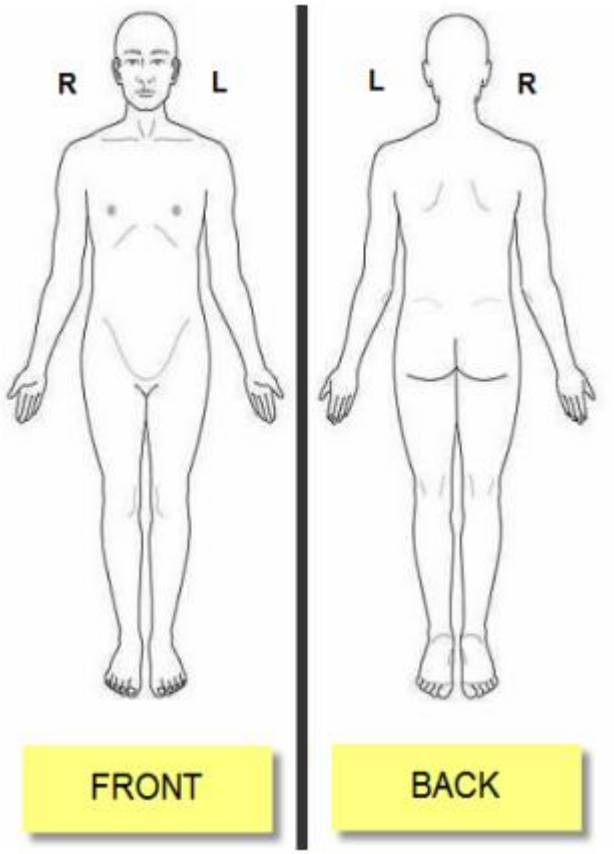
_____

Have you had a similar problem before? If yes, when?

_____

What medical imaging tests or treatments have you had for this problem? (Example: prior MRI, surgery, etc.)

_____

Mark location of **METAL** implants or devices only. (Not pain.)	FOR TECHNOLOGISTS NOTES ONLY
	

PLEASE READ PRIOR TO SIGNING:

You must remove all metallic objects including: easily removable jewelry, bra, shoes, belts, hair pins, safety pins, paperclips, money clips, coins, pens, watch, etc. If you have any body piercing, other than ears, please let the technologist know. Your signature on this form indicates that you authorize and consent to performance of this procedure.

Patient Signature or Representative (if minor) **Date** **MRI Technologist** **Date**