McLaren Flint

# PATIENT INTERVIEW AND HISTORY

MRI

(PLEASE PRINT)

Patient Name: _____ Birth Date: ____ / ____ / ____

| Yes | No | | Yes | No | |
|---|---|---|---|---|---|
| ❑ | ❑ | Pacemaker * If Yes Please Notify Staff * | ❑ | ❑ | Stroke |
| ❑ | ❑ | Cardiac Defibrillator (ICD) * If Yes Please Notify Staff * | ❑ | ❑ | Seizures |
| ❑ | ❑ | Brain Aneurysm Clips * If Yes Please Notify Staff * | ❑ | ❑ | Diabetes |
| ❑ | ❑ | Ear Surgery | ❑ | ❑ | High Blood Pressure |
| ❑ | ❑ | Metal in Body or Eyes | ❑ | ❑ | Arthritis |
| ❑ | ❑ | Surgical Implants | ❑ | ❑ | Pregnancy |
| ❑ | ❑ | Prosthesis | ❑ | ❑ | Kidney Disease |
| ❑ | ❑ | Abdominal Aortic Aneurysm Surgery (Year: _____) | ❑ | ❑ | Allergies *if yes _____ |
| ❑ | ❑ | History of Cancer (Type: _____) (When Diagnosed: _____) | | | |
| ❑ | ❑ | Does patient require additional assistance? Explain _____ | | | |

Patient's Signature: _____ Date: ____ / ____ / ____

## ⬇********** OFFICE USE ONLY **********⬇

Exam: _____ Diagnosis: _____

Pertinent Surgeries and Dates: _____

Current Signs, Symptoms, Location: _____

_____

_____

❑ Non-Traumatic? Date of onset: _____

❑ Traumatic? Date of injury: _____

Ht: _____

Wt: _____

CONTRAST DOSAGE _____

Type of injury: ❑MVA ❑Sports ❑Lifting ❑Fall ❑Other: _____

Intensity: ❑Progressively improving ❑Progressively worsening ❑No Change

Physical Therapy: ❑No ❑Yes ❑Beneficial ❑ Somewhat beneficial ❑Non-beneficial

Medications: _____

Other Tests for current medical condition: _____

_____

Interviewer: _____ Date: ____ / ____ / ____

PT.

MR.#/RM.

DR.