

PAIN SHEET

Chest Evaluation

Last Name

First

Middle Init. Age

Today's Date

THESE QUESTIONS APPLY ONLY TO THE AREA BEING SCANNED TODAY

1. What was your chief complaint when you visited your doctor? _____

2. What do you think caused the problem? _____

3. What does your doctor think is causing your Problem? _____

4. Describe your pain: _____
 - a. Does anything make it worse? _____
 - b. Does anything make it better? _____
5. Do you have any weakness? _____ Where? _____

6. Have you had surgery or arthroscopy to the area being scanned today? _____
When? _____
What was done? _____
7. Do you have arthritis in any of your joints? _____
8. Do you have any other medical conditions? _____

9. Are you taking any medications? _____ What kind? _____
10. Describe your general health: _____

PLEASE COMPLETE BOTH SIDES

Patient History and Safety Screening

PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS:

Current Weight _____ (Needed for calibration of the MRI machine.)

YES NO

— — Cardiac Pacemaker

— — Brain Vessel Clips

— — Aortic Clips

— — Artificial Heart Valve

— — Coronary, Artery or Heart Surgery, if yes, when? _____

— — Insulin Pump

— — Electrodes

— — Tens Unit or Pain Stimulating Unit

— — Ear Surgery or Implants

— — Hearing Aids

— — Metal fragments in the head, eye or skin

— — Have you ever worked with metal or as a Metal Worker?

— — Metal Plates, Pins, Screws, Nails or Clips

— — Any previous Skull Surgery

If Yes, what was the surgery for: _____

— — Is there any chance you are pregnant?

(Not recommended for women in their first trimester of pregnancy)

Signature of Patient: _____

Signature of Parent or Guardian: _____

Date: _____

PLEASE COMPLETE BOTH SIDES