



PATIENT ELIGIBILITY CHECKLIST

PLEASE ANSWER ALL QUESTIONS ON BOTH SIDES OF THIS QUESTIONNAIRE!

PATIENT NUMBER
DATE OF BIRTH
WEIGHT

PATIENT NAME

LAST FIRST MIDDLE

PATIENT CRITERIA

- Is there a possibility that you are pregnant? YES NO
- Are you presently or have you ever been a welder, sheet metal, auto welding or steel worker? YES NO
- Has metal ever entered your eyes? YES NO
- Have you ever had brain surgery? YES NO
 Please list type of surgery: _____
- Have you ever had chest surgery? YES NO
 Please list type of surgery: _____
- Other surgery? YES NO
 Please list type of surgery: _____

5. Do you have any of the following? **PLEASE CIRCLE YOUR ANSWER**

- | | | | |
|-------------------------------------|--------|----------------------------------|--------|
| Aneurysm Clips | YES NO | Intracranial Bypass Clips | YES NO |
| Renal Transplant Clips | YES NO | Coronary Artery Bypass Clips | YES NO |
| CARDIAC PACEMAKER | YES NO | Mitral Cardiac Valve Prosthesis | YES NO |
| Cochlear ear implants | YES NO | Neuro or Biostimulator | YES NO |
| IUD (Copper) | YES NO | Orbital Prosthesis (Eye Implant) | YES NO |
| Artificial Limb/Joint Prosthesis | YES NO | What Type _____ | |
| Epilepsy/Seizures | YES NO | Harrington Rods (Scoliosis) | YES NO |
| Vena Cava Umbrella | YES NO | Cardiac Arrhythmias | YES NO |
| Shrapnel, Metallic Splinter, Bullet | | Acupuncture Needles | YES NO |
| or other Foreign Bodies | YES NO | Permanent Eye Liner (tattoo) | YES NO |

- Previous MRI? YES NO Where? _____
- Previous CT Scan? YES NO Where? _____
- Have you had any other pertinent exams? YES NO Type/Where? _____

9. DO YOU HAVE ANY OF THE FOLLOWING?

- | | | | |
|----------------|--------|-----------|-------|
| Allergies | YES NO | DESCRIBE: | _____ |
| Cancer | YES NO | DESCRIBE: | _____ |
| Diabetes | YES NO | DESCRIBE: | _____ |
| Anemia | YES NO | DESCRIBE: | _____ |
| Asthma | YES NO | DESCRIBE: | _____ |
| Heart Disease | YES NO | DESCRIBE: | _____ |
| Liver Disease | YES NO | DESCRIBE: | _____ |
| Blood Disorder | YES NO | DESCRIBE: | _____ |

10. Please list any allergies to medication: _____

Please list any medications you are currently taking: _____

11. How did you hear about our facility? *EXPLAIN* _____

FOR SPINE STUDIES PLEASE COMPLETE THIS SECTION

12. DO YOU HAVE PAIN, TINGLING, NUMBNESS OR WEAKNESS IN ANY THESE AREAS?

CERVICAL SPINE			THORACIC/LUMBAR SPINE		
Neck	Right	Left	Lower Back	Right	Left
Arm	Right	Left	Buttocks/legs	Right	Left
Hand	Right	Left	Lower leg/feet	Right	Left

What symptoms are you experiencing? _____

Do you have bowel and/or bladder difficulties? YES NO

Have you had spine surgery? YES NO When? _____ At what level? _____

FOR KNEE:(circle) RIGHT LEFT

13. *WHEN* and *HOW* did you injure your knee? _____

If no injury, please *DESCRIBE* your symptoms and the *DATE OF ONSET* _____

Where does your knee hurt?(circle)	FRONT	BACK	INSIDE	OUTSIDE
Did you feel something pop?	YES	NO		
Do you feel something moving in the joint?	YES	NO		
Does your knee "lock"?	YES	NO		
Do you hear a "click"?	YES	NO		
Have you had surgery to this knee?	YES	NO	<i>WHEN?</i>	_____
What repair was done to your knee?	_____			

FOR HAND—WRIST—SHOULDER—FOOT—ANKLE and any other musculoskeletal area

14. Was there an injury? YES NO *EXPLAIN* _____

Are you experiencing pain? YES NO *EXPLAIN* _____

What is the *DATE OF ONSET* for your pain? _____

FOR ALL OTHER AREAS: BRAIN—CHEST—ABDOMEN—SOFT TISSUE NECK

15. Please describe your symptoms _____

DATE OF ONSET of symptoms _____

I have understood and answered all of the above eligibility statements.

Patient's Signature _____ Date: _____

Technologist's Signature _____ Date: _____