New West
sports medicine & orthopaedic surgery
2810 W. 35th Street, Kearney, NE 68845

UPPER EXTREMITY EXAMINATION HISTORY

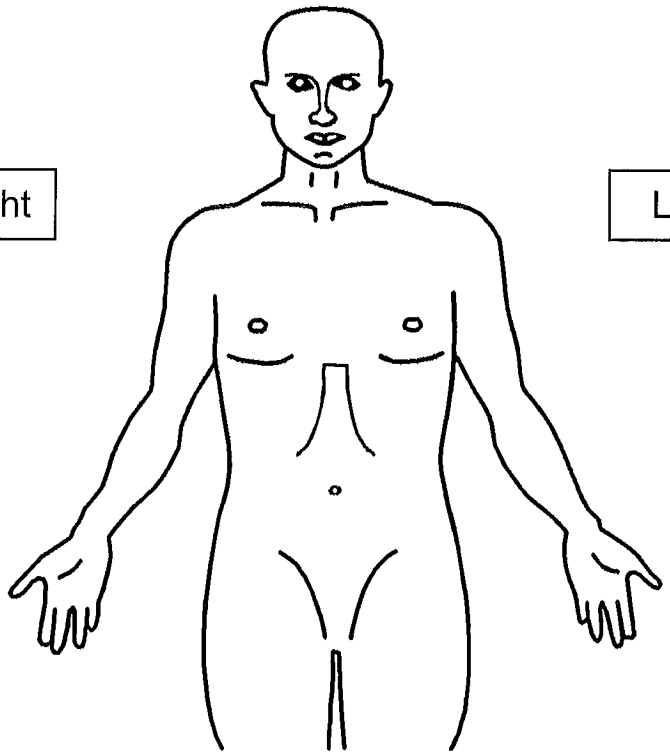
Patient: Age: Sex: Exam Date:

Referred by: Weight:

Please shade area where you have had pain or other symptoms including numbness or tingling

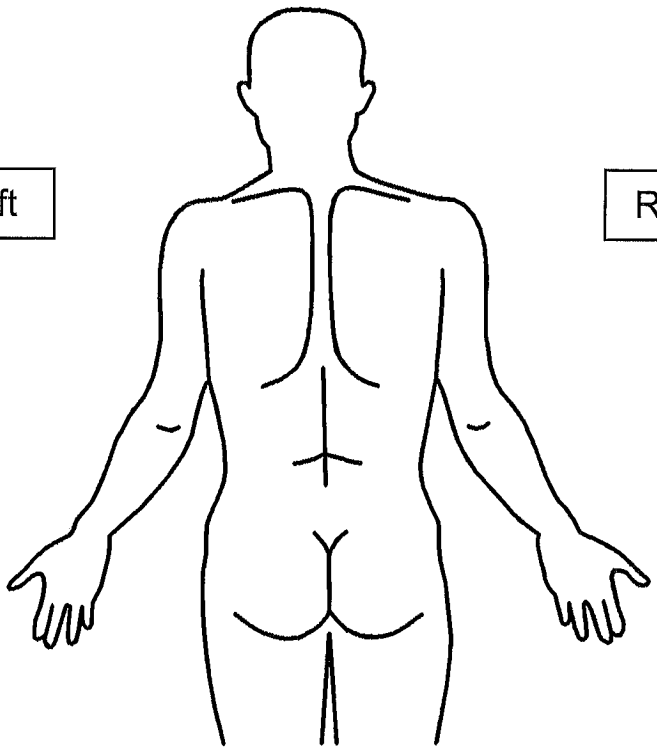
Front

Right Left



Back

Right Left



		Right	Left
1.	Are you having pain, numbness, or tingling?	Yes/No	Yes/No
2.	Do you have trouble picking up objects?	Yes/No	Yes/No
3.	Do you have loss of grip strength?	Yes/No	Yes/No
4.	Do you unexpectedly drop objects?	Yes/No	Yes/No
5.	Is this result of an accident? If yes, date_____ Explain:	Yes/No	Yes/No
6.	Is this a result of a sport injury? If yes, please explain:	Yes/No	Yes/No
7.	Have you had previous surgery? When?_____	Yes/No	Yes/No
8.	Do you have pain, popping, locking, or catching in your shoulder?	Yes/No	Yes/No

Patient Signature_____ **Date** _____

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MAGNETIC RESONANCE IMAGING
PATIENT SAFETY SCREENING HISTORY

Patient Name: _____

Date: _____ Date of Birth _____

Exam _____

The following items may interfere with MR Imaging and some may be hazardous to your safety. Please circle if you have or have had any of the following (if yes, please explain):

A heart/cardiac pacemaker	Yes	No	_____
Any type of implanted electrode or wire	Yes	No	_____
Heart bypass surgery	Yes	No	_____
Insertion of heart valve	Yes	No	_____
Brain/aneurysm clips	Yes	No	_____
Aortic or other blood vessel clips	Yes	No	_____
Insertion of a neurostimulator (Tens Unit)	Yes	No	_____
Insertion of an insulin of drug pump	Yes	No	_____
Hearing aid or surgery for hearing loss	Yes	No	_____
Insertion of any “shunt” or “stent” device	Yes	No	_____
Metal plates, pins, screws, nails or rods	Yes	No	_____
Insertion of metal implants or prosthesis	Yes	No	_____
Partial plate or dentures	Yes	No	_____
Shrapnel or bullet wounds	Yes	No	_____
Work with metal (welding/grinding)	Yes	No	_____
Metal in or removed from your eyes	Yes	No	_____
Any known allergies	Yes	No	_____
Pregnant, possibly pregnant, or nursing	Yes	No	_____
Breast implants or IUD	Yes	No	_____
Nitroglycerine patches	Yes	No	_____
Piercings, Tattoos	Yes	No	_____
Permanent Make-up	Yes	No	_____
Are you claustrophobic?	Yes	No	_____

Please list the following:

Previous surgery _____

Previous diagnostic studies on area being scanned _____

Notes: Anyone entering the scan room should remove all metal or magnetic objects, including watches, keys, hearing aids, credit cards, pagers, hair pins, jewelry, safety pins, coins, eyeglasses, pens, tools and etc.

MRIs performed at New West are reviewed by a radiologist to ensure an accurate diagnosis. You will receive a separate bill from the radiologist for this service.

The above information is accurate to the best of my knowledge.

_____ _____
Patient Signature Date

_____ _____
Parent/Guardian Signature Date

_____ _____
Technologist’s Signature Date

Arthrogram
Contrast_____ Amount_____ Site _____ Time_____ Injector’s initials _____