

McLaren Print System Order

Order No: 63665
Order Date: 2021-07-14
User: Jodi Peterman
Phone: 3422133

Ship Location: Jodi Peterman - McLaren Flint MRI Ballenger
750 S Ballenger Hwy
Flint, MI 48532

Forms

Quantity: 1000
Paragon Dept No: 32113
Dept Name: McLaren Flint MRI Ballenger
Company Number: 60

Order Total Price: 136.00

Item Number: 17848
Item Description: MRI Patient Interview & History
Revision Date: 7/2021
Print: 1 sided full color
Paper: 20# White Text
Size: 8.5 x 11
Fold:
Finish: None
Drill: None
Misc Info: ss; color no bleed

McLaren Flint
FLINT HOSPITAL

PATIENT INTERVIEW AND HISTORY

(PLEASE PRINT)

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

<input type="checkbox"/> <input type="checkbox"/> Pacemaker * If Yes Please Notify Staff *	<input type="checkbox"/> <input type="checkbox"/> Stroke
<input type="checkbox"/> <input type="checkbox"/> Cardiac Defibrillator (ICD) * If Yes Please Notify Staff *	<input type="checkbox"/> <input type="checkbox"/> Seizures
<input type="checkbox"/> <input type="checkbox"/> Brain Aneurysm Clips * If Yes Please Notify Staff *	<input type="checkbox"/> <input type="checkbox"/> Diabetes
<input type="checkbox"/> <input type="checkbox"/> Ear Surgery	<input type="checkbox"/> <input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> <input type="checkbox"/> Metal in Body or Eyes	<input type="checkbox"/> <input type="checkbox"/> Arthritis
<input type="checkbox"/> <input type="checkbox"/> Surgical Implants	<input type="checkbox"/> <input type="checkbox"/> Pregnancy
<input type="checkbox"/> <input type="checkbox"/> Prostheses	<input type="checkbox"/> <input type="checkbox"/> Kidney Disease
<input type="checkbox"/> <input type="checkbox"/> Magnetic Eyelashes	<input type="checkbox"/> <input type="checkbox"/> Allergies "I yes" _____
<input type="checkbox"/> <input type="checkbox"/> Abdominal Aortic Aneurysm Surgery (Year _____)	
<input type="checkbox"/> <input type="checkbox"/> History of Cancer (Type _____) (When Diagnosed _____)	
<input type="checkbox"/> <input type="checkbox"/> Does patient require additional assistance? Explain _____	

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

Is patient displaying altered mental status and/or have a history of dementia? Yes No If YES review form with Family or Appropriate Individual

Name _____ Relationship _____

******* OFFICE USE ONLY *******

Exam: _____ **Diagnosis:** _____

Patient Surgeries and Dates: _____

Current Signs, Symptoms, Location: _____

Non-Traumatic? **Date of onset:** _____ **FI:** _____

Traumatic? **Date of injury:** _____ **MI:** _____

Type of Injury: Chock Sports Lifting Fall Other _____

Severity of Pain: Mild Moderate Severe (Severity ____/10)

Physical Therapy: No Yes Beneficial Somewhat beneficial Non-beneficial

Medications: _____

Other tests for current medical condition: _____

Paragon Patient Profile Reviewed for Previous Procedures, Devices/Implants Yes No

Interviewer: _____ **Date:** ____ / ____ / ____

Medication Guide Given Initials _____

MR PATIENT INTERVIEW AND HISTORY
08/01/21

 63665

Spec Info: