

**McLaren Print System Order**

**Order No: 71618**  
**Order Date: 2022-08-04**  
**User: Jodi Peterman**  
**Phone: 3422133**

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

**Forms**

**Quantity: 500**  
**Paragon Dept No: 32113**  
**Dept Name: McLaren Flint MRI Ballenger**  
**Company Number: 60**

**Order Total Price: 68.00**

**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**  
**Poster:**  
**Misc Info: ss; color no bleed**

McLaren Flint  
Form 10000000000000000000

**PATIENT INTERVIEW AND HISTORY**

(PLEASE PRINT)

**Patient Name:** \_\_\_\_\_ **Birth Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

<input type="checkbox"/> <input type="checkbox"/> Pacemaker * <b>If Yes Please Notify Staff *</b>	<input type="checkbox"/> <input type="checkbox"/> Stroke
<input type="checkbox"/> <input type="checkbox"/> Cardiac Defibrillator (ICD) * <b>If Yes Please Notify Staff *</b>	<input type="checkbox"/> <input type="checkbox"/> Seizures
<input type="checkbox"/> <input type="checkbox"/> Brain Aneurysm Clips * <b>If Yes Please Notify Staff *</b>	<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"/> Prosthetics	<input type="checkbox"/> <input type="checkbox"/> Kidney Disease
<input type="checkbox"/> <input type="checkbox"/> Magnetic Eyeglasses	<input type="checkbox"/> <input type="checkbox"/> Allergies "If yes, _____"
<input type="checkbox"/> <input type="checkbox"/> Abdominal Aortic Aneurysm Surgery (Year _____)	
<input type="checkbox"/> <input type="checkbox"/> History of Cancer (Type _____) (Other 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:** \_\_\_\_\_

**Pertinent Surgeries and Dates:** \_\_\_\_\_

**Current Signs, Symptoms, Location:** \_\_\_\_\_

**Non-Traumatic?** **Date of onset:** \_\_\_\_\_ **HC:** \_\_\_\_\_

**Traumatic?** **Date of injury:** \_\_\_\_\_ **MC:** \_\_\_\_\_

**Type of Injury:**  Laceration  Sports  Lifting  Fall  Other \_\_\_\_\_

**Severity of Pain:**  Mild  Moderate  Severe (Severity \_\_\_\_/10)

**Analgesic Therapy:**  No  Yes  Beneficial  Somewhat beneficial  Non-beneficial

**Medications:** \_\_\_\_\_

**Other Tests for current medical condition:** \_\_\_\_\_

Paragon Patient Profile Reviewed for Previous Procedures: (Diagnosis/History)  Yes  No

**Interviewer:** \_\_\_\_\_ **Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Medication Guide Given  Initials \_\_\_\_\_

MSI-PATIENT INTERVIEW AND HISTORY  
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