

MRI Scan Review Request

Provided that your most recent study is less than 12 months old, Dr. Dick will review your neck and back MRI, CT scans and/or plain x-rays and discuss them with you over the telephone. There will be no obligation or charge to you.

Please print this MRI Review Request form and the Patient Intake Form. Fill them out completely. Enclose *copies* of your studies on a CD (the CDs will not be returned) and mail them to:

Jeffrey C. Dick, MD
MRI Scan Review
Twin Cities Orthopedics
4010 West 65th Street
Edina, MN 55435

Name:

Day/Evening phone & extension:

Address:

Best time to call (circle):

Morning Afternoon Evening

City/State/Zip:

How did you learn about TCO?

By filling out the MRI request form you agree that:

- Your personally identifiable health care information can be shared with employees of Twin Cities Orthopedics.
- The MRI review is for information only and is not a substitute for the more thorough evaluation that occurs during an in person appointment.
- A written evaluation and medical diagnosis can only be provided if you are personally examined by a physician at TCO at which time there will be an appointment charge.
- I understand and agree to the above terms and conditions and request a complimentary review of my scans and x-rays for informational purposes only.

Signature _____ Date _____.

Patient Name: _____
 Birthdate ____/____/____
 Today's Date ____/____/____

PATIENT HEALTH HISTORY

PLEASE COMPLETE PAGE 1 AND 2

Physician you are seeing today _____

Who referred you to our office? _____ Clinic: _____

PAST MEDICAL HISTORY		Do you have a personal history of any of the following: (none or circle)
General	<input type="checkbox"/> None	Cancer Diabetes Thyroid disease Delayed wound healing Malignant hyperthermia Hepatitis AIDS/HIV Difficulty with anesthesia
Heart/Circulation	<input type="checkbox"/> None	MI/Heart Attack Blood Clots High Blood Pressure Stroke Abnormal Rhythm Pacemaker Bleeding disorders
Lungs	<input type="checkbox"/> None	Asthma Emphysema Oxygen dependence Bronchitis
Gastrointestinal	<input type="checkbox"/> None	Ulcers Appendectomy Gallbladder surgery Crohn's Disease Reflux/GERD
Neuro/Psych	<input type="checkbox"/> None	Depression Anxiety disorder Schizophrenia Seizures Chemical Dep
Musculoskeletal	<input type="checkbox"/> None	Arthritis Gout Fracture Ligament injury/Sprain Fibromyalgia Previous Orthopedic Surgery Bone joint infections
Other		List:

HOSPITALIZATIONS/SURGERIES	YEAR
List all previous hospitalizations and/or surgeries	<input type="checkbox"/> None

MEDICATIONS	
List any medications you are taking and why. Include herbs, inhalers, non-prescription medications <input type="checkbox"/> None	
Dosage/Frequency	Dosage/Frequency

To your knowledge, have you ever taken Prednisone/Cortisone by mouth? yes no don't know

ALLERGIES	
List any medications you are sensitive to and the reaction	<input type="checkbox"/> None

Have you ever had a reaction to: eggs shellfish/iodine latex rubber

Do you use tobacco in any form? yes no Quit # ____ years If yes, # per day ____ # of years ____
 Do you drink alcohol? yes no Quit # ____ years If yes, # per week ____ # of years ____
 Have you ever used recreational drugs? yes no List:

FAMILY HISTORY (Grandparents, parents, siblings)	
Do you have a family history of any of the following? <input type="checkbox"/> None	
<input type="checkbox"/> diseases of muscles, bones, or nervous system	<input type="checkbox"/> difficulty with anesthesia
<input type="checkbox"/> arthritis <input type="checkbox"/> rheumatoid <input type="checkbox"/> osteoarthritis	<input type="checkbox"/> diabetes
<input type="checkbox"/> bleeding disorders <input type="checkbox"/> blood clots	<input type="checkbox"/> infectious diseases
If yes, please explain:	

WORK / SOCIAL HISTORY

Marital status single married separated divorced widowed
 Children yes no How many? _____ Ages _____
 Do you live alone with family assisted living nursing home other
 Are you currently working? yes no If no, when did you last work? _____
 Occupation: _____ Employer _____ How long? _____
 Is your regular work? Heavy Medium Light Sedentary
 Are you currently on any work restrictions? yes no If yes, what are they? _____

 Do you exercise or participate in sports on a regular basis? yes no If yes, Please explain:

REVIEW OF SYSTEMS (check None or circle any that apply)

General	<input type="checkbox"/> None	Recent unexplained weight loss or gain fatigue fever chills night sweating risk factors HIV/AIDS
Eyes	<input type="checkbox"/> None	double vision blurred vision blind spots glasses/contact lenses glaucoma cataracts legally blind
Ears/Nose/Throat	<input type="checkbox"/> None	ringing in ears difficulty hearing use hearing aid deaf (read lips; ASL) frequent nose bleeds hoarseness dry mouth sinus problems dentures/partial plate/braces/caps
Lungs	<input type="checkbox"/> None	chronic cough wheezing shortness of breath pneumonia coughing blood
Heart/circulation	<input type="checkbox"/> None	chest pain leg swelling hands/feet always cold leg cramps varicose veins easy bruising
Gastrointestinal	<input type="checkbox"/> None	stomach ulcers problems with bowel movements heartburn nausea swallowing problems
Genitourinary	<input type="checkbox"/> None	incontinence painful urination blood in urine trouble starting stream
Reproductive	<input type="checkbox"/> None	pregnant possible pregnancy menopause prostate problems
Musculoskeletal	<input type="checkbox"/> None	joint pain joint swelling stiffness arthritis gout muscle or tendon injuries fractures childhood deformities or braces
Skin	<input type="checkbox"/> None	rashes lumps sores color changes change in hair or nails skin tears easily difficulty healing skin
Neurological	<input type="checkbox"/> None	numbness or tingling weakness pins and needles tremors/shaking seizures dizziness fainting
Endocrine	<input type="checkbox"/> None	thyroid heat or cold intolerance when others are comfortable excessive thirst excessive sweating
Psychiatric	<input type="checkbox"/> None	depression anxiety excessive stress nervousness panic attacks

Patient Signature: _____ **Date** _____

Physician/Non-Physician Signature _____ **Date** _____

UPDATES OR CHANGES

Date	Remarks	Initial

Spine Pain Questionnaire

Patient Sticker

Patient Name: _____ Date: _____

Referred By: _____

Date of Birth: _____ Height: _____ Weight: _____ Age: _____

What is the reason you are seeing the orthopedic surgeon:

- Evaluation and treatment 2nd opinion Disability rating

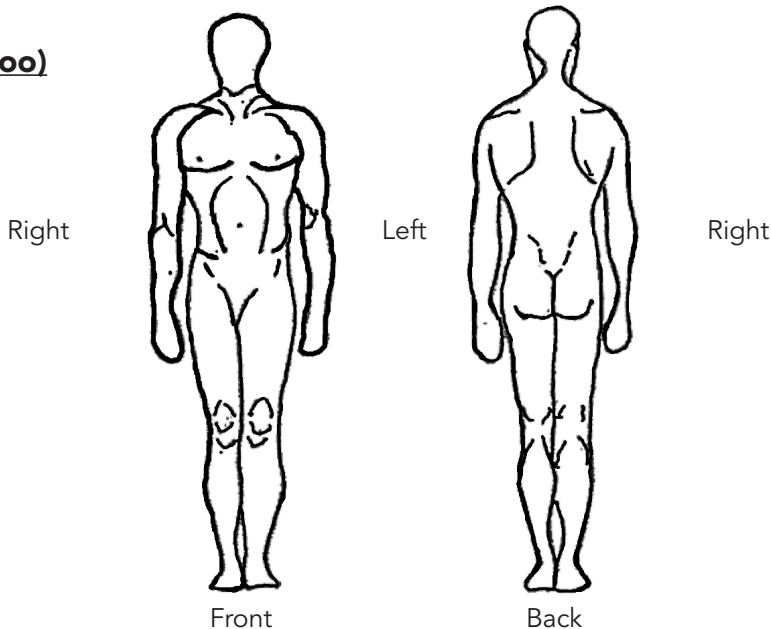
History of Current Problems.

1. Date that your back or neck problems started? _____
2. Have you had a similar problem in the past? No Yes If yes, when _____
Please describe: _____
3. Is your current problem the result of a: No injury that you know of Work injury
Motor vehicle accident Other injury If an injury, give **Date of Injury?** _____
4. Has litigation or claim for compensation been initiated? No Yes
5. Please briefly describe how your current back/neck and/or leg/arm problems first began:

Symptom (Pain) Diagram – Please use the diagrams below to indicate the area of your symptoms and the type of symptoms you are experiencing. Use the appropriate symbol. Include all affected areas.

Sharp Pain (///)
Pins/Needles (ooo)

Aching Pain (xxx)
Numbness (+++)
Burning (BBB)



How much of your problem is in your back or leg? **Back** _____ % + **Leg** _____ % = **100%**

If you have pain in your legs, which is worse: Right _____ Left _____ Equal _____

How much of your problem is in your neck or arm? **Neck** _____ % + **Arm** _____ % = **100%**

If you have pain in your arms, which is worse: Right _____ Left _____ Equal _____

Description of Symptoms

Pain Scale:

0 = No Pain

10 = Worst Pain Possible

1. When my pain is at its worst, it is a _____ (Pick a number from the above pain scale).
2. When my pain is at its best, it is a _____ (Pick a number from the above pain scale).
3. Most of the time, my pain is a _____ (Pick a number from the above pain scale).
4. Have you noticed weakness in any muscles since your problem began? No Yes*
 *If yes, please describe: _____
5. How far do you estimate you can walk? _____ Feet or _____ Miles or Unlimited

Treatment

What medications are you currently taking for your pain? _____

What medications have you taken in the past for your pain? _____

List the physicians you have seen for this problem. _____

How many times have you been treated by the following professionals?

Physical Therapist: _____. When? _____. Chiropractor: _____ When? _____

Have you had any of the following spinal treatments?

Epidural Steroid Injections Trigger-Point Injections Facet Injections Other: _____
 When? _____ When? _____ When? _____ When? _____

Please list any surgeries you have had on your spine?

Date	Surgeon	Procedure
_____	_____	_____
_____	_____	_____
_____	_____	_____

Check any of the following tests or studies you have had and give the date they were done.

X-Ray _____	CT Scan _____
MRI Scan _____	EMG Test _____
Discogram _____	Bone density _____
Other _____	None of the above