



REGIONAL IMAGING & THERAPEUTIC RADIOLOGY SERVICES, P.C.  
360 Bard Avenue • Staten Island, New York 10310

# 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

- |   |     |    |
|---|-----|----|
| 1. Is there a possibility that you are pregnant?  | YES | NO |
| 2. Are you presently or have you ever been a welder, sheet metal, auto welding or steel worker? | YES | NO |
| 3. Has metal ever entered your eyes?  | YES | NO |
| 4. 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 |
| <b>CARDIAC PACEMAKER</b>            | 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 |

- |                  |     |    |              |
|------------------|-----|----|--------------|
| 6. Previous MRI? | YES | NO | Where? _____ |
|------------------|-----|----|--------------|

- |                      |     |    |              |
|----------------------|-----|----|--------------|
| 7. Previous CT Scan? | YES | NO | Where? _____ |
|----------------------|-----|----|--------------|

- |  |     |    |                   |
|--|-----|----|-------------------|
| 8. 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: _____ |

**PLEASE COMPLETE BOTH SIDES OF QUESTIONNAIRE - THANK YOU**

10. Please list any medications you are currently taking:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**FOR SPINE STUDIES PLEASE COMPLETE THIS SECTION**

**11. CERVICAL SPINE**

**THORACIC/LUMBAR SPINE**

DO YOU HAVE PAIN, TINGLING, NUMBNESS OR WEAKNESS IN ANY OF THE FOLLOWING AREAS?

	<b>RIGHT</b>	<b>LEFT</b>		<b>RIGHT</b>	<b>LEFT</b>		
Upper Arm	_____	_____	(C5)	Buttocks	_____	_____	(S1)
Elbow	_____	_____	(C6)	Front of Thigh	_____	_____	(L1-2)
Lower Arm	_____	_____	(C7)	Back of Thigh	_____	_____	(L5-S1)
Hand & Fingers	_____	_____	(C8-T1)	Foot near big toe	_____	_____	(L5)
				Foot near small toe	_____	_____	(S1)

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

Have you had previous significant spine injury? YES NO

If yes describe: \_\_\_\_\_

**12. FOR KNEE - ANKLE - FOOT - SHOULDER - & ANY OTHER MUSCULOSKELETAL AREA COMPLETE THIS SECTION:**

Any history of fractures? YES NO Date of Fracture \_\_\_\_\_

Please describe symptoms \_\_\_\_\_

\_\_\_\_\_

**13. FOR ALL OTHER AREAS: BRAIN, CHEST, ABDOMEN, SOFT TISSUE NECK**

Please describe your symptoms \_\_\_\_\_

\_\_\_\_\_

Date of onset of symptoms: \_\_\_\_\_

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

Patient's Signature \_\_\_\_\_ Date: \_\_\_\_\_

I have reviewed the above criteria with the patient.

NAME: \_\_\_\_\_ Date: \_\_\_\_\_