

MRI History Form

PATIENT INFORMATION

Fall Precaution YES NO

Last Name	First Name/Middle Initial	Gender	Race
Date of Birth (MM/DD/YYYY) / /	Age	Height	Weight

PERSONAL HISTORY Please indicate if you have any of the following

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Swan-Ganz or thermodilution catheter | <input type="checkbox"/> Yes <input type="checkbox"/> No | Shunt (spinal or ventricular) |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Cardiac Pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tissue expander (e.g. breast) |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Implanted Cardioverter defibrillator (ICD) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Any type of prosthesis (limb, eye, penile, etc) |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Aneurysm Clip(s) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Metallic Stent, filter, or coil |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Eyelid spring or wire | <input type="checkbox"/> Yes <input type="checkbox"/> No | IUD, diaphragm, or pessary |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart valve prosthesis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Wire mesh, surgical staples, clips, metallic sutures |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Neuro or Spinal Cord Stimulator | <input type="checkbox"/> Yes <input type="checkbox"/> No | Medication Patch (Nicotine, Nitroglycerine) |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Internal electrodes or wires | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tattoo of permanent make-up |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Bone growth / Bone Stimulator | <input type="checkbox"/> Yes <input type="checkbox"/> No | Dentures or partial plates |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Cochlear, otologic, or other ear implant | <input type="checkbox"/> Yes <input type="checkbox"/> No | Body piercing jewelry |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Implanted drug/insulin infusion device | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hearing Aid |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Joint replacement (hip, knee, etc.) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Any metallic fragment or shavings, BB, shrapnel or foreign body (including eye injuries) |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Bone/joint pin, screw, nail, wire, plate, etc) | | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Any other implant: _____ | | |

Have you ever had an allergic reaction to injected MRI contrast? YES NO

If yes, please explain: _____

- | | | | |
|--|------------------|--|--------------------------------|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Seizure Disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease/ Kidney Failure |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Dialysis |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart or Blood Disease |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Allergies | If yes, please specify: _____ | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Surgeries | If yes, please specify: _____ | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Cancer | If yes, please specify: _____ | |

FEMALE PATIENTS ONLY

Some imaging procedures are contra-indicated (not recommended) for patients who may be pregnant. If you may be pregnant, please notify one of our team members. By my signature below, I acknowledge that I have read and understand this statement and state that I am not pregnant and there is no chance that I may be pregnant.

Are you breastfeeding YES NO Date of last period: _____

ACKNOWLEDGMENT

I have answered these questions to the best of my knowledge and understand the information presented to me. If I am to have intravenous contrast with my procedure, I have been informed of the risks.

PARENT/ GUARDIAN SIGNATURE

DATE

TECHNOLOGIST SIGNATURE

DATE