MRI History Sheet

Today's Date_____ Name_____ Date of Birth_____
Sex_____ Weight _____ Height_____ Age _____

Allergies: _____
_____

Please List All Surgeries and Invasive Procedures: _____
_____
_____
_____

Please *Explain* your reason for having this exam: _____
_____
_____
_____
_____

If your symptoms are related to an injury what **DATE** and **LOCATION** did the injury occur?

___/____/_____

Please Circle Location: Home Work Motor Vehicle Accident Other:_____

Please circle if you have: pain, numbness, tingling, swelling, weakness

Please circle: Right Arm, Right Leg, Left Arm, Left Leg, Neck, Mid Back, Lower Back,

Other: _____

Have you ever had surgery to the area being examined? YES or NO

- **If yes, when and what type of surgery**:___/___/_____ _____

Please circle if you have: Anemia, any disorder that affects the blood, Diabetes, Seizures, Lupus, Sarcoidosis, a history of renal (kidney) disease

Please circle if you have: osteoarthritis, rheumatoid arthritis, psoriatic arthritis, osteoporosis, cancer, degenerative disk disease, multiple sclerosis, hypertension, ankylosing spondylitis

Please list any other medical conditions you have: _____
_____

Please Continue on the Back Side of this Paper!

For Technologist Use Only:

Tech Initials_____
IV Contrast □ Yes □ No Brand _____ Lot _____ Exp _____CCs Injected _____
BUN _____ CREATININE _____ EGFR _____ Date Drawn_____
Exam:

History:

Please Indicate If You Have Any Of The Following:

□ Yes □ No Aneurysm Clips
□ Yes □ No Aortic Stent Graft
□ Yes □ No Cardiac Pacemaker or Defibrillator
□ Yes □ No Electronic Implant or Device
□ Yes □ No Magnetically Activated Implant or Device
□ Yes □ No Neurostimulation System or Spinal Cord Stimulator
□ Yes □ No Internal Electrodes or Wires
□ Yes □ No Bone Growth Stimulator or Bone Fusion Stimulator
□ Yes □ No Cochlear, Otologic, or Other Ear Implant (Stapes Implant)
□ Yes □ No Implanted Drug Infusion Pump or Device
□ Yes □ No Vascular Access Port
□ Yes □ No Heart Valve Replacement
□ Yes □ No Eyelid Spring, Wire, or other Eye Implants
□ Yes □ No Screw, Pin, Nail, Wire, or Plate in any Bone or Joint
□ Yes □ No Joint Replacement (Knee, Hip, etc.)
□ Yes □ No Artificial or Prosthetic Limb
□ Yes □ No Metallic Stent, Coil, or Filter (Heart Stent, Greenfield Filter, etc.)
□ Yes □ No Shunt (Spinal or Intraventricular)
□ Yes □ No Any Metallic Fragment or Foreign Body (Metal in the Eye, Bullet, etc.)
□ Yes □ No Surgical Staples, Clips, or Metallic Suture
□ Yes □ No Wire Mesh Implant (Hernia Repair)
□ Yes □ No Any Type of Prosthesis (Eye, Penile, etc.)
□ Yes □ No Permanent Make-up or Tattooed Make-up (Eyeliner or Lipstick)
□ Yes □ No Body Piercing
□ Yes □ No Medication Patch (Nicotine, Nitroglycerine, Pain Medication, etc.)
□ Yes □ No Dentures or Partial Plates
□ Yes □ No Hearing Aides (***Please Remove Before Entering the MRI Room***)
□ Yes □ No Claustrophobia
□ Yes □ No Kidney Disease
□ Yes □ No Diabetes
□ Yes □ No Any Other Implants _____

Females:

Date of the First Day of Last Menstrual Period:_____

□ Yes □ No Are You Currently Breast Feeding
□ Yes □ No Do You Have an IUD or Diaphragm

I have read and understand the contents of this form. I have answered the above questions correctly to the best of my ability.

Patient Signature:_____ Date:____/____/____

IMPORTANT INSTRUCTIONS

Before entering the MR environment or MR system room, you must remove **ALL** metallic objects including hearing aids, dentures, partial plates, keys, beepers, cell phone, hair pins, barrettes, jewelry, body piercing jewelry, watch, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knives, nail clippers, tools, clothing with metal fasteners, and clothing with metallic threads. A keyed locker will be provided to store these objects.

Please Consult the MRI Technologist if you have any questions **BEFORE** you enter the MR system room. The MR system is **ALWAYS** on.