

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 MRI: _____

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: Type 1 Type 2: Insulin Dependent: No Yes
- Yes No Any Other Implants _____

Females:

Date of Last Menstrual Period: _____

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

Patients receiving Gadolinium Contrast:

I have received the FDA required Medication Guide. I consent to the administration of the contrast. Yes N/A

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: _____

Today's 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.