MRI History Sheet

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

Females:
Date of Last Menstrual Period: _____
Are You Currently Breast Feeding? ☐ Yes ☐ No Do You Have an IUD? ☐ Yes ☐ No

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 Indicate Location:

☐ Home ☐ Work ☐ Motor Vehicle Accident ☐ Other: _____

Please Indicate if you have:

☐ Pain ☐ Numbness ☐ Tingling ☐ Swelling ☐ Weakness

Please Indicate Location of Symptoms:

☐ Right Arm ☐ Right Leg ☐ Left Arm ☐ Left Leg
☐ Neck/Cervical Spine ☐ Mid Back/Thoracic Spine ☐ Lower Back/Lumbar Spine
☐ Other: _____

Have you ever had surgery to the area being examined? ☐ Yes ☐ No

When and What Type of Surgery: ___/___/_____ _____

Please indicate if you have:

☐ Anemia ☐ Seizures ☐ Lupus ☐ Sarcoidosis ☐ Any disorder that affects the blood
☐ Osteoarthritis ☐ Rheumatoid Arthritis ☐ Psoriatic Arthritis ☐ Multiple Sclerosis
☐ Degenerative Disk Disease ☐ Hypertension/High Blood Pressure
☐ Ankylosing Spondylitis ☐ Cancer: _____

Please list any other medical conditions you have: _____

_____

Please indicate if you HAVE or HAD any of the following by checking YES or NO,
Check type of implant or location if indicated

□ Yes □ No Aneurysm Clips or Coils
□ Yes □ No Stent: ☐Coronary/Heart, ☐Aortic, ☐Iliac, ☐Biliary, ☐Ureteral, ☐Peripheral, ☐Other
□ 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 Implanted Bone Growth Stimulator or Bone Fusion Stimulator
□ Yes □ No Cochlear, Otologic, Inner Ear Implant (Stapes Implant), Other Ear Implant
□ Yes □ No Implanted Drug Infusion Pump or Device: Morphine Pump, Insulin Pump
□ Yes □ No Vascular Access Port, Chemo Port
□ Yes □ No Heart Valve Replacement
□ Yes □ No Eyelid Spring, Wire, Cataract Lens Implant, Retinal Repair, Other Eye Implant
□ Yes □ No Joint Replacement: Knee, Hip, Shoulder, Other
□ Yes □ No Screw, Pin, Nail, Wire, or Plate in any Bone or Joint
□ Yes □ No IVC Filter, Greenfield Filter
□ Yes □ No Shunt: Spinal, Intraventricular
□ Yes □ No Any Metallic Fragment or Foreign Body: Metal in Eye, Bullet, Other
□ Yes □ No Surgical Staples, Clips, or Metallic Suture
□ Yes □ No Wire Mesh Implant: Hernia Repair, Bladder Sling
□ Yes □ No Any Type of Prosthesis: Eye, Penile, Limb, Other
□ Yes □ No Permanent Make-up or Tattooed Make-up: Eyeliner, Lipstick
□ Yes □ No Body Piercing, Dermal
□ Yes □ No Medication Patch: Nicotine, Nitroglycerine, Pain Medication, Other
□ Yes □ No Dentures or Partial Plates
□ Yes □ No Hearing Aides (***Must be Removed Before Entering the MRI Room***)
□ Yes □ No Claustrophobia
□ Yes □ No Kidney Disease/Renal Disease
□ Yes □ No Diabetes: ☐ Type 1 ☐ Type 2: Insulin Dependent: ☐ No ☐ Yes
□ Yes □ No Continuous Glucose Monitor (***Must be Removed Before Entering the MRI Room***)
□ Yes □ No Any Other Implants _____

IMPORTANT INSTRUCTIONS

Before entering the MR environment or MR system room, you must remove **ALL** metallic objects including hearing aids, dentures, partial plates, keys, 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, and tools. You will be required to change into a provided gown or attire. A keyed locker will be provided to store your items. Please leave any valuables and non-essential metallic items at home. Please Consult the MRI Technologist if you have any questions **BEFORE** you enter the MR system room. The MR system is **ALWAYS** on.

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: _____