



MRI HISTORY FORM

Patient Name: _____

DOB: _____ Age: _____ Height: _____ Current weight: _____

Have you had a previous imaging study related to this problem? Yes No

If yes. What exam? CT MRI Ultrasound X-ray Other What Facility? _____

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 implant Surgical staples, clips, or 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: _____ | |

PERSONAL HISTORY

Have you ever had a previous allergic reaction to injected MRI contrast Yes No

If yes, 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: _____

ACKNOWLEDGEMENT

I attest that the above information is correct to the best of my knowledge. I read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and regarding the MR procedure that I am about to undergo. If I am to have intravenous contrast with my MRI, I have been informed of the risks of possible allergic reactions and that patients with kidney disease can suffer serious effects by receiving gadolinium based contrast agents.

Patient/ Guardian Signature: _____ Date: _____

Technologists Signature: _____ Date: _____