

Name : \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Chart # \_\_\_\_\_

Ordering Physician: \_\_\_\_\_ Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

MRI Scan: \_\_\_\_\_ Notes: \_\_\_\_\_

**Do you have or have you ever had any of the following?**

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Implanted Cardiac Pacemaker/Defibrillator                             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Claustrophobia                                |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Surgery/ Valves/Stents/Shunts/Filters/Coils                     | <input type="checkbox"/> Yes <input type="checkbox"/> No | Dentures/Partials/Dental Implants             |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Eye Surgery/Implants/Spring/Wires/Retinal Tack                        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Gunshot Wounds/Shrapnel/BB                    |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Injury to the Eye Involving Metal or Metal Shavings                   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Brain Aneurysm Clips/ Brain Surgery           |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Mesh Implants/Wire Sutures or staples/Clips/Internal Electrodes       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Previous MRI for this area of the body?       |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Implanted Drug Infusion Pumps/Ports/Catheters                         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ear Surgery/Cochlear Implants/Hearing Aids    |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Using any medication in the form of a topical patch                   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Orthopedic pins/Screws/Rods/Joints/Prosthesis |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Tattoo's/Permanent Make-up/Body Piercing/Patches                      | <b>List any Drug Allergies:</b> _____                    |   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you have pins in your Hair/Clothes/Hair Extensions/Hair Pieces/Wig |  |   |

**Previous Treatments** (if any) please provide a brief description if applicable. **(Physical Therapy, Chiropractic, Injections, etc):**

1. What is your main complaint? \_\_\_\_\_ For How Long? \_\_\_\_\_
2. Describe your pain, (i.e. sharp, burning, dull, etc.). \_\_\_\_\_
3. Does anything make the pain worse? If so, what? \_\_\_\_\_
4. Do you have numbness? \_\_\_\_\_ Weakness? \_\_\_\_\_ If so Please Explain \_\_\_\_\_
5. Have you had any injury/trauma to this area? \_\_\_\_\_ Explain. \_\_\_\_\_
6. What type of surgery, if any, was done on this area of your body? When? \_\_\_\_\_
7. Have you ever been diagnosed with cancer? \_\_\_\_\_ When? \_\_\_\_\_  
What Kind and Where in body? \_\_\_\_\_
8. Have you had radiation/chemotherapy? \_\_\_\_\_
9. Any problems with dizziness or being off-balance? \_\_\_\_\_ Explain \_\_\_\_\_
10. Please list any medical conditions that you have: \_\_\_\_\_

**MRI Contrast History:** (Please circle Yes or No)

- |                                      |          |  |          |
|--------------------------------------|----------|--|----------|
| Have you ever had MRI contrast?      | Yes / No | Any history of Hypertension?               | Yes / No |
| Did you have any kind of reaction?   | Yes / No | Any history of Diabetes?                   | Yes / No |
| Are you pregnant at this time?       | Yes / No | History of Severe Kidney or Liver Disease? | Yes / No |
| Are you breast feeding at this time? | Yes / No | Pending Kidney or Liver Transplant?        | Yes / No |

Sometimes MRIs requires an injection of contrast. MRI contrast (Gadolinium) is non-iodine based and is administered through an intravenous injection. During administration, you may experience a sensation of contrast material being injected, which is normal and expected. MRI Contrast is quite safe, however, as with all medications there is a slight risk of an allergic reaction. The physician and staff in the MRI Department are trained to respond to any emergency situation that may develop.

I attest that the above information is correct to the best of my knowledge. I have had the opportunity to ask questions related to this form, to ask questions regarding the MRI procedure, and I understand the information presented to me.

X \_\_\_\_\_  
Patient/Parent/Legal Guardian MRI Technologist's Signature Date

\_\_\_\_\_  
Amount & Type of Contrast Lot Number Expiration Date