MRI History

Patient Name (Printed): _____ Birth Date: _____

Acct.#: _____

THE FOLLOWING ITEMS MAY BE HAZARDOUS OR INTERFERE WITH MRI.
PLEASE ANSWER CAREFULLY. DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING:

- ☐ Yes ☐ No Pacemaker/Pacemaker wires or Heart valve/Heart surgery/Stent?
- ☐ Yes ☐ No Implanted cardiac defibrillator?
- ☐ Yes ☐ No Brain aneurysm clip/Other brain surgery?
- ☐ Yes ☐ No Ear surgery/Cochlear Implant/Inner ear prosthesis/Hearing aids?
- ☐ Yes ☐ No Vascular access port/Central venous catheter?
- ☐ Yes ☐ No Metal slivers in eye/History of welding or metal grinding?
- ☐ Yes ☐ No Eye surgery/Ocular implants?
- ☐ Yes ☐ No Shrapnel/Bullet fragments/BBs/Other metal foreign body?
- ☐ Yes ☐ No Neurostimulator/TENS/muscle stimulator (pelvic floor, etc)?
- ☐ Yes ☐ No Removable dentures or partials?
- ☐ Yes ☐ No Diaphragm/IUD?
- ☐ Yes ☐ No Penile implant/Pessary/metal mesh?
- ☐ Yes ☐ No IVC filter/Joint replacement/metal plates, surgical clips, staples or screws, orthopedic implants?
- ☐ Yes ☐ No Tattoos/Piercing with metal jewelry/Permanent makeup?
- ☐ Yes ☐ No Do you have Diabetes or Insulin pump/Pain pump?
- ☐ Yes ☐ No Do you have a history of cancer? If so, what type? _____
- ☐ Yes ☐ No Do you have a history of kidney (renal) disease, including kidney disease secondary to collagen vascular disease (Lupus, Scleroderma, etc.) or multiple myeloma?
- ☐ Yes ☐ No Do you have a history of kidney failure, kidney tumor, kidney surgery, kidney transplant, or renal dialysis?
- ☐ Yes ☐ No Are you wearing a transdermal patch (e.g., Nicotine patch)?
- ☐ Yes ☐ No Any type of intravascular coil, filter or stent?
- ☐ Yes ☐ No Any type of electronic, mechanical or magnetic implant?
- ☐ Yes ☐ No Are you breast feeding?
- ☐ Yes ☐ No Are you pregnant or suspect you might be pregnant? Date of last menstrual period _____
- ☐ Yes ☐ No Have you had lumbar spine surgery?
- ☐ Yes ☐ No Do you have active gout?
- ☐ Yes ☐ No Artificial limb/prosthesis?
- ☐ Yes ☐ No Do you have high blood pressure?
- ☐ Yes ☐ No Do you have any allergies including drug allergies?

If yes, what are you allergic to: _____

DESCRIBE YOUR SYMPTOMS OR THE REASON YOU ARE HAVING TODAY'S MRI:

_____

HAVE YOU HAD A PREVIOUS X-RAY, CT OR MRI OF THE AREA BEING SCANNED TODAY?

If yes, list what was done and where it was performed: _____

_____

I understand the above information and I have answered the questions to the best of my knowledge. I have had the opportunity to ask questions about the information on this form that I did not understand.

_____ _____

Patient Signature Date

Optimal Imaging | Sacred Heart Health System

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