

Please print clearly

Patient name \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Patient weight \_\_\_\_\_

Referring physician \_\_\_\_\_

Briefly describe the problems you are having \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

List any surgeries you have had \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Have you had any previous MR or CT scans for this problem?  Yes  No

If so, when and where? \_\_\_\_\_

**Certain items may interfere with the MRI procedure. Some items may be hazardous to your health.**

It is *very important* to inform the MRI staff of any of the following: (Place a check mark if yes.)

- |  |   |
|--|---|
| <input type="checkbox"/> Cardiac pacemaker   | <input type="checkbox"/> Aneurysm clip(s)                                   |
| <input type="checkbox"/> Cardiac defibrillator   | <input type="checkbox"/> Neurostimulator                                    |
| <input type="checkbox"/> Artificial heart valve  | <input type="checkbox"/> Internal electrodes                                |
| <input type="checkbox"/> Hearing aids  | <input type="checkbox"/> Ear implants                                       |
| <input type="checkbox"/> Eye implants/prosthesis   | <input type="checkbox"/> Implanted drug device (pain pump)                  |
| <input type="checkbox"/> Dentures/partial plates   | <input type="checkbox"/> Implants held in place by magnets                  |
| <input type="checkbox"/> Surgical clips/staples  | <input type="checkbox"/> Vascular access ports                              |
| <input type="checkbox"/> Swan-Ganz catheter  | <input type="checkbox"/> Intraventricular shunt                             |
| <input type="checkbox"/> Biostimulators  | <input type="checkbox"/> IUD  |
| <input type="checkbox"/> Diaphragm   | <input type="checkbox"/> Penile prosthesis                                  |
| <input type="checkbox"/> Artificial limbs or joints  | <input type="checkbox"/> Tattoos/body piercings                             |
| <input type="checkbox"/> Any other implanted item (please list)  | <input type="checkbox"/> Any type of shrapnel, foreign body or bullets      |
| _____  | <input type="checkbox"/> Metal slivers in eyes                              |
| _____  | <input type="checkbox"/> Any type of intravascular coils, stents or filters |
| <input type="checkbox"/> Any implanted orthopedic device (pins, plates, screws, nails, wires, clips, etc.) |   |
| <input type="checkbox"/> Transdermal Patches   |   |

**Do you have/or have you ever had any of the following conditions: (Place a check mark if yes.)**

- |  |   |
|--|---|
| <input type="checkbox"/> Cancer                            | <input type="checkbox"/> Diabetes                 |
| <input type="checkbox"/> Heart Condition                   | <input type="checkbox"/> Conditions               |
| <input type="checkbox"/> Renal Condition                   | <input type="checkbox"/> Communicable disease     |
| <input type="checkbox"/> Liver Condition                   | <input type="checkbox"/> Chance of pregnancy      |
| <input type="checkbox"/> Surgery in the area to be scanned | <input type="checkbox"/> Currently breast-feeding |

I attest that the above information is correct to the best of my knowledge. I have read and understand the contents of this form and have had the opportunity to ask questions regarding the information on this form.

**Patient Signature** \_\_\_\_\_ **Date** \_\_\_\_/\_\_\_\_/\_\_\_\_

MR Technologist comments \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_