OUTPATIENT DIAGNOSTIC CENTER

MRI History Form

PATIENT INFORMATION **Fall Precaution** ☐ YES ☐ NO

Last Name	First Name/Middle Initial	Gender	Race
Date of Birth (MM/DD/YYYY) / /	**Age**	**Height**	**Weight**

PERSONAL HISTORY Please indicate if you have any of the following

☐ Yes ☐ No	Swan-Ganz or thermodilution catheter	☐ Yes ☐ No	Shunt (spinal or ventricular)
☐ Yes ☐ No	Cardiac Pacemaker	☐ Yes ☐ No	Tissue expander (e.g. breast)
☐ Yes ☐ No	Implanted Cardioverter defibrillator (ICD)	☐ Yes ☐ No	Any type of prosthesis (limb, eye, penile, etc)
☐ Yes ☐ No	Aneurysm Clip(s)	☐ Yes ☐ No	Metallic Stent, filter, or coil
☐ Yes ☐ No	Eyelid spring or wire	☐ Yes ☐ No	IUD, diaphragm, or pessary
☐ Yes ☐ No	Heart valve prosthesis	☐ Yes ☐ No	Wire mesh, surgical staples, clips, or metallic sutures
☐ Yes ☐ No	Neuro or Spinal Cord Stimulator	☐ Yes ☐ No	Medication Patch (Nicotine, Nitroglycerine)
☐ Yes ☐ No	Internal electrodes or wires	☐ Yes ☐ No	Tattoo of permanent make-up
☐ Yes ☐ No	Bone growth / Bone Stimulator	☐ Yes ☐ No	Dentures or partial plates
☐ Yes ☐ No	Cochlear, otologic, or other ear implant	☐ Yes ☐ No	Body piercing jewelry
☐ Yes ☐ No	Implanted drug/insulin infusion device	☐ Yes ☐ No	Hearing Aid
☐ Yes ☐ No	Joint replacement (hip, knee, etc.)	☐ Yes ☐ No	Any metallic fragment or shavings, BB, shrapnel or foreign body (including eye injuries)
☐ Yes ☐ No	Bone/joint pin, screw, nail, wire, plate, etc.)		
☐ Yes ☐ No	Any other implant: _____		

Have you ever had an allergic reaction to injected MRI contrast? ☐ YES ☐ NO

If yes, please explain: _____

☐ Yes ☐ No	Seizure Disorder	☐ Yes ☐ No	High Blood Pressure
☐ Yes ☐ No	Asthma	☐ Yes ☐ No	Kidney Disease/ Kidney Failure
☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Dialysis
☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Heart or Blood Disease

☐ Yes ☐ No **Allergies** **If yes, please specify:** _____

☐ Yes ☐ No **Surgeries** **If yes, please specify:** _____

☐ Yes ☐ 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: _____

ACKNOWLEDGMENT

I have answered these questions to the best of my knowledge and understand the information presented to me.
If I am to have intravenous contrast with my procedure, I have been informed of the risks.

_____ _____

PARENT/ GAURADIAN SIGNATURE **DATE**

_____ _____

TECHNOLOGIST SIGNATURE **DATE**