# 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, 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,** |
| ☐ Yes ☐ No | **Bone/joint pin, screw, nail, wire, plate, etc)** | | **shrapnel or foreign body (including eye injuries)** |
| ☐ 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.

_____ _____

**PATIENT/GUARDIAN SIGNATURE** **DATE**

_____ _____

**TECHNOLOGIST SIGNATURE** **DATE**