

Male Female
Weight: _____ **Height:** _____ **Age:** _____
Date of last menstrual cycle: _____
Allergies :(Please list) _____

Present medical history (Please mark if you have currently)

Yes <input type="checkbox"/>	No <input type="checkbox"/>	Pregnancy – known or possible	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Kidney or liver disease
<input type="checkbox"/>	<input type="checkbox"/>	Breastfeeding	<input type="checkbox"/>	<input type="checkbox"/>	Asthma/ Allergic respiratory disorders
<input type="checkbox"/>	<input type="checkbox"/>	Diabetic	<input type="checkbox"/>	<input type="checkbox"/>	Anemia/ Blood disorders
<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Post Menopausal

Have you ever had surgery other than dental? Yes No (Please circle)

List Date and Type: _____

1. Head _____
2. Neck _____
3. Chest _____
4. Abdomen _____
5. Extremities _____
6. Spine _____

Do you have a history of cancer? Yes No (Please circle)

If yes, what is your primary cancer site? _____

Please give us a brief description of your problems or symptoms: _____

How long have you been having these problems? _____

Were you injured? _____
(If yes, describe) _____

Have you had surgery in this area?

No Yes When? _____

Describe if possible _____

Have you had any other exams related to this current problem or symptoms?

X-rays No - Yes When? _____

Where? _____

CT Scan No - Yes When? _____

Where? _____

MRI No - Yes When? _____

Where? _____

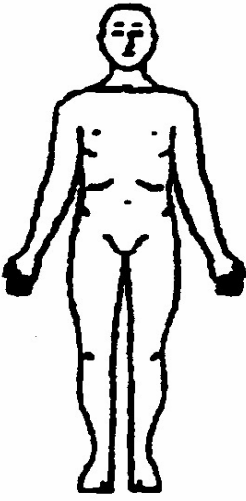
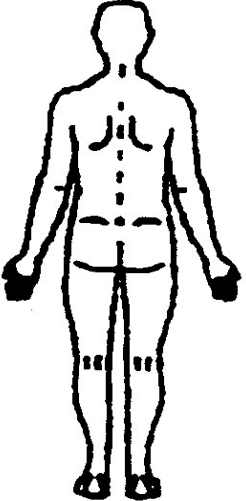
Ultrasound No - Yes When? _____

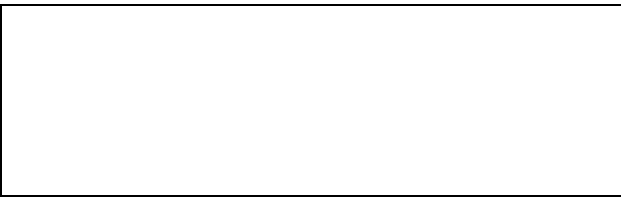
Where? _____

Bone Scan No - Yes When? _____

Where? _____

Circle the areas below and check the symptoms

Right	Left	Left	Right
			
MARK ALL AREAS THAT APPLY TO YOU:			
Right	Left	Right	Left
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arm Pain		Leg Pain	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neck Pain		Mid Back Pain	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low Back Pain		Weakness	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tingling		_____	



THE FOLLOWING ITEMS MAY BE HARMFUL TO YOU DURING YOUR MRI SCAN OR MAY INTERFERE WITH THE MRI EXAMINATION. YOU MUST CHECK YES or NO to the following items:

- | YES | NO | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Any type of electronic, mechanical, or magnetic implant (Type _____) |
| <input type="checkbox"/> | <input type="checkbox"/> | Cardiac pacemaker |
| <input type="checkbox"/> | <input type="checkbox"/> | Aneurysm clip(s) |
| <input type="checkbox"/> | <input type="checkbox"/> | Implanted cardiac defibrillator |
| <input type="checkbox"/> | <input type="checkbox"/> | Neurostimulator |
| <input type="checkbox"/> | <input type="checkbox"/> | Biostimulator (Type _____) |
| <input type="checkbox"/> | <input type="checkbox"/> | Any type of internal electrodes or wires |
| <input type="checkbox"/> | <input type="checkbox"/> | Any type of ear implant (e.g., Cochlear, Stapes implant) |
| <input type="checkbox"/> | <input type="checkbox"/> | Sheet Metal Worker – Do you <u>always</u> wear goggles? No <input type="checkbox"/> Yes <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | A history of metal fragments in eye – Did you seek medical attention? No <input type="checkbox"/> Yes <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Hearing aids |
| <input type="checkbox"/> | <input type="checkbox"/> | Implanted drug pump (e.g., insulin, Baclofen, chemotherapy, pain medicine) |
| <input type="checkbox"/> | <input type="checkbox"/> | Spinal fixation device (e.g., Halo Vest, Harrington Rod) |
| <input type="checkbox"/> | <input type="checkbox"/> | Spinal fusion procedure |
| <input type="checkbox"/> | <input type="checkbox"/> | Any type of coil, filter, or stent (Type _____) |
| <input type="checkbox"/> | <input type="checkbox"/> | Any type of metal object (e.g., shrapnel, BB, bullet) |
| <input type="checkbox"/> | <input type="checkbox"/> | Artificial heart valve |
| <input type="checkbox"/> | <input type="checkbox"/> | Penile implant |
| <input type="checkbox"/> | <input type="checkbox"/> | Artificial Eye |
| <input type="checkbox"/> | <input type="checkbox"/> | Eyelid spring |
| <input type="checkbox"/> | <input type="checkbox"/> | Any type of implant held in place by a magnet (Type _____) |
| <input type="checkbox"/> | <input type="checkbox"/> | Surgical clips or staples |
| <input type="checkbox"/> | <input type="checkbox"/> | Any I.V. access port (e.g., Broviac, Port-a-Cath, Hickman, Picc line) |
| <input type="checkbox"/> | <input type="checkbox"/> | Medication patch (e.g., Nitroglycerine, nicotine) |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart bypass surgery |
| <input type="checkbox"/> | <input type="checkbox"/> | Shunt |
| <input type="checkbox"/> | <input type="checkbox"/> | Artificial limb or joint replacement (What and where _____) |
| <input type="checkbox"/> | <input type="checkbox"/> | Tissue expander (e.g., breast) |
| <input type="checkbox"/> | <input type="checkbox"/> | Removable dentures, false teeth, or partial plate |
| <input type="checkbox"/> | <input type="checkbox"/> | Diaphragm, IUD, Pessary (Type _____) |
| <input type="checkbox"/> | <input type="checkbox"/> | Surgical mesh (Location _____) |
| <input type="checkbox"/> | <input type="checkbox"/> | Body piercing (Location _____) |
| <input type="checkbox"/> | <input type="checkbox"/> | Tattoos or permanent eyeliner |
| <input type="checkbox"/> | <input type="checkbox"/> | Wig, hair implants |
| <input type="checkbox"/> | <input type="checkbox"/> | Radiation seeds (e.g., cancer treatment) |
| <input type="checkbox"/> | <input type="checkbox"/> | Fractured bones treated with metal rods, plates, screws, nails or clips |
| <input type="checkbox"/> | <input type="checkbox"/> | Breast implants |
| <input type="checkbox"/> | <input type="checkbox"/> | Other _____ |

Some studies may require an injection of an intravenous contrast material (Gadolinium). During the injection you may feel the sensation of the contrast 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 most common reactions are minor reactions such as headache, nausea and dizziness in less than 5% of those injected. More serious reactions occur very infrequently such as difficulty breathing and irregular heartbeat. As with many drugs cardiac and/or respiratory arrest occurs very rarely. The chance of these more serious reactions is less than 1%. Please let the staff know if you have had a previous allergic reaction to MRI contrast.

I have read the above information and answered the questions to the best of my knowledge.

I have directed any questions regarding the above information or the examination itself to the MRI staff.

I consent to have a Magnetic Resonance Imaging Study.

X

Signature of Patient or Guardian

Date

Technologist Signature