

# MRI PATIENT HISTORY

Patient Name: \_\_\_\_\_  
 Date Of Birth: \_\_\_\_\_  
 Referring Physician: \_\_\_\_\_  
 Primary Care Physician: \_\_\_\_\_  
 Emergency Contact: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_  
 Relationship: \_\_\_\_\_

**TO OUR PATIENTS AND ACCOMPANYING FAMILY MEMBERS...**

The MR room contains a very strong magnet. Before you are allowed to enter, we must know if you have any metal in your body. Some metal objects can interfere with your scan or may even be dangerous, so PLEASE answer the following questions carefully. If you have a question regarding anything on this form, PLEASE DO NOT HESITATE TO ASK US!

Yes  No Have you ever had an operation or surgery of any kind? If so, please list them all with dates.

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Yes  No Are you claustrophobic?

Yes  No Have you ever been a machinist, welder, or metalworker?

Yes  No Have you ever been hit in the face or eye with a piece of metal (including metal shavings, slivers, bullets or BBs)?

Yes  No Have you ever had a piece of metal removed from your eye?

Yes  No Are you pregnant, possibly pregnant, or breast feeding?

Yes  No Any history of seizures?

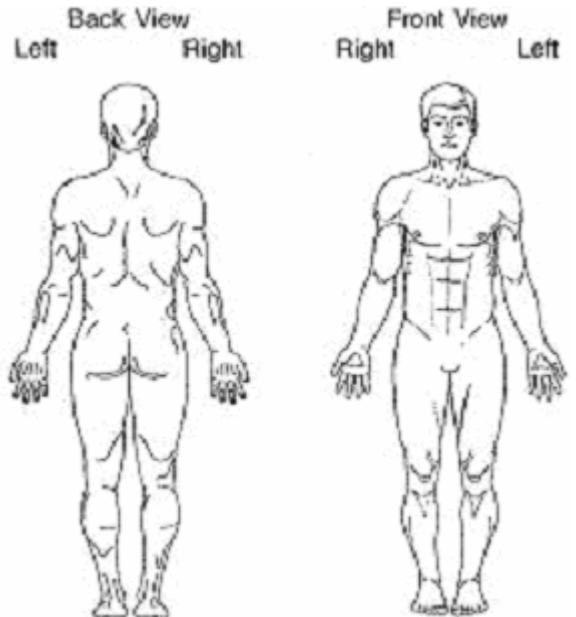
**Do you have any of these items in your body?**

- |                              |                             |   |
|------------------------------|-----------------------------|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Pacemaker, wires, or defibrillator                |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Body piercing                                     |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Brain aneurysm clip                               |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Ear implant                                       |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Eye implant                                       |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Electrical stimulator for nerves or bone          |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Bullets, BBs, or pellets                          |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Metal shrapnel or fragments                       |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Magnetic implant anywhere                         |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Infusion pump                                     |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Coil, filter, or wire in blood vessel             |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Artificial limb or joint                          |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Eyelid tattoo                                     |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Implanted catheter or tube                        |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Artificial heart valve                            |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Penile prosthesis                                 |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Shunt   |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | False teeth, retainers, or magnetic braces        |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Surgical clips, staples, wires, mesh, or stitches |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Diaphragm or intrauterine device                  |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Ortho devices (plates/screws/pins/rods/wires)     |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Bone growth/fusion stimulator/tissue expander     |

The following items may become damaged or cause injury to others in a strong magnetic field. THEY MUST NOT BE TAKEN INTO THE SCAN ROOM. Please check off any of these items you may have with you today.

- |  |   |
|--|---|
| <input type="checkbox"/> Hearing Aid             | <input type="checkbox"/> Purse/pocketbook         |
| <input type="checkbox"/> Glasses                 | <input type="checkbox"/> Pens/pencils             |
| <input type="checkbox"/> Watch                   | <input type="checkbox"/> Keys                     |
| <input type="checkbox"/> Safety Pins             | <input type="checkbox"/> Coins                    |
| <input type="checkbox"/> Hairpins/barrettes      | <input type="checkbox"/> Pocketknife              |
| <input type="checkbox"/> Wigs/hair pieces        | <input type="checkbox"/> Credit or bank cards     |
| <input type="checkbox"/> Jewelry                 | <input type="checkbox"/> Belt                     |
| <input type="checkbox"/> Wallet/money clip       | <input type="checkbox"/> Buckle/Suspenders        |
| <input type="checkbox"/> Metal zippers / buttons | <input type="checkbox"/> Bra/girdle/sanitary belt |
| <input type="checkbox"/> Medication Patches      |   |

**Please mark on this drawing the location of any metal inside your body.**



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

Signature (Parent or Guardian)

Date Signed: \_\_\_\_\_