MAGNETIC RESONANCE IMAGING (MRI) PATIENT INFORMATION / ASSESSMENT

4941

Patient Legal Name: _____
(Last) (First) (Middle Initial)

Date of Birth: _____/_____/_____ **Age:** _____ **Height:** _____ **Weight:** _____ (lbs.)

Have you had surgery on the area being scanned today: ☐ Yes ☐ No If yes, when? _____

Previous radiology exams on the area being scanned today: ☐ Yes ☐ No

***If yes*, what type of exam:** ____ X-RAY ____ Cat Scan ____ Ultra Sound ____ MRI ____ PET

Briefly describe why your doctor wants this MRI: _____

_____

_____

How long have you had these symptoms:_____

Location of pain: *(please shade in painful area)*

Check whether pain is right, left, or both:

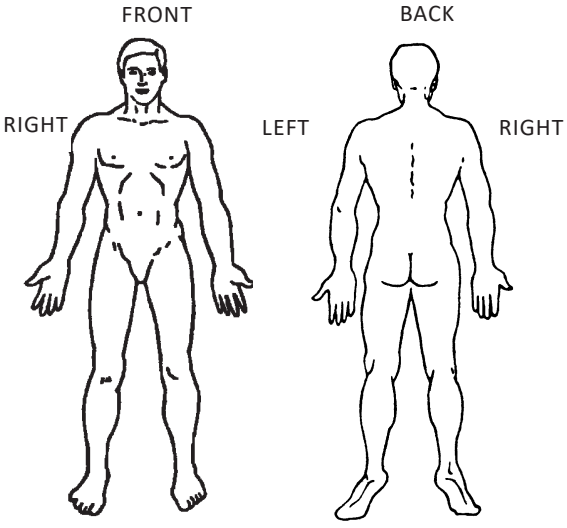
Type	Right	Left	Both
Numbness	☐	☐	☐
Leg pain	☐	☐	☐
Tingling	☐	☐	☐
Weakness	☐	☐	☐

Describing pain, select all that apply:

____ Sharp ____ Dull

____ Shooting ____ Constant

____ Intermittent



Is this MRI the result of an accident or injury: ☐ Yes ☐ No

***If yes,* explain:** _____

Date of accident/injury:_____

Type of accident/injury:_____

If motor vehicle accident, were you the driver: ☐ Yes ☐ No

What speed were you going at the time of the accident: _____ mph/km

Were you restrained: ☐ Yes ☐ No

Location of accident/injury:_____

Any previous treatments for accident/injury: ☐ Yes ☐ No

Are you pregnant: ☐ **Yes,** _____ weeks ☐ No

Do you have a history of: ☐ Asthma ☐ Diabetes ☐ Kidney Disease ☐ Heart Disease ☐ Renal Failure ☐ Dialysis ☐ Kidney transplant or solitary kidney ☐ Multiple Myeloma ☐ Hypertension

Have you ever been diagnosed with a tumor: ☐ Yes ☐ No

***If yes,* please list type and site:** _____

Have you ever been diagnosed with cancer: ☐ Yes ☐ No **Had radiation treatment:** ☐ Yes ☐ No

***If yes,* please list type and site:** _____

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PATIENT ID LABEL

YES NO

1. ☐ ☐ Are you allergic to MRI (Gadolinium based) contrast?
2. ☐ ☐ Do you have any mechanical devices implanted in your body? (i.e. pain pump, insulin pump, neuro stimulators, defibrillator or pacemaker) ** If you have a pacemaker, you may not be able to have a MRI.**
3. ☐ ☐ Do you have an aneurysm clip implanted in your brain? If so, when: _____
   Name of manufacturer: _____ Model # _____
4. ☐ ☐ Do you have any devices to make bones grow (like bone growth or bone fusion stimulators)?
5. ☐ ☐ Do you have implants in your ear (like a cochlear implant)? If so, when:_____
   Name of manufacturer: _____ Model # _____
6. ☐ ☐ Do you have a filter for blood clots (umbrella, Greenfield, bird's nest)? If so, date implanted: _____
   Name of manufacturer: _____ Model # _____
7. ☐ ☐ Do you have embolization coils (Gianturco)?
8. ☐ ☐ Do you have implants, other than cataract lens implants in your eyes?
9. ☐ ☐ Do you have any stents (small tubes used to keep blood vessels open)? Where:_____
   Name of manufacturer: _____ Model # _____
10. ☐ ☐ Do you have an artificial arm or leg? If so, *it must be removed.*
11. ☐ ☐ Do you wear a transdermal patch to deliver medication through the skin? If yes, *it must be removed prior to your MRI procedure and replaced with a new patch following your MRI.*
    List medication: _____
12. ☐ ☐ Have you ever worked in a machine shop?
    If so, do you have any metal embedded in your hands, face or eyes? ___Y___N Where is it:_____
13. ☐ ☐ Have you ever had metal or a foreign object removed from your eye(s) by a doctor?
    If so, have you had a complete eye exam since the removal of the metal or foreign object from your eye(s)? ___Y___N
14. ☐ ☐ Have you ever had a gunshot wound?
    If so, is there gunshot residue still in your body? ___Y___N
15. ☐ ☐ Do you have any body piercings or jewelry: If so, *they must be removed.* Rings are OK.
16. ☐ ☐ Do you have a hearing aid or dentures? *All hearing aids must be removed.*
    Dentures are OK unless having a brain or neck MRI.
17. ☐ ☐ Do you have a "shunt" (a tube to drain fluid) in your brain, spine or heart?
18. ☐ ☐ Do you have surgically implanted metal joints, rods, plates, pins, screws, or clips in any part of your body?
    If so, where:_____
19. ☐ ☐ Do you have a tattoo or permanent makeup?
    If yes, was it done professionally? ___Y___N
20. ☐ ☐ Do you get upset or anxious in small spaces?
21. ☐ ☐ For WOMEN: Do you use an, IUD, or cervical pessary?
    If so, name of manufacturer: _____ Model # _____
22. ☐ ☐ For MEN: Do you have implants in your penis?
    If so, name of manufacturer: _____ Model # _____

PLEASE READ AND SIGN

I have answered the above questions to the best of my ability and I understand that possible injury could result if I withhold vital information.

I understand that in the event I am unable to complete this exam, there will be a reduced charge to cover the facilities cost. A reduced service claim will be submitted to any applicable insurance.

PATIENT ID LABEL

_____ _____ _____
PATIENT SIGNATURE DATE TIME

_____ _____ _____
TECHNOLOGIST SIGNATURE DATE TIME