

Name _____ Date _____

SEX: F ___ M ___ Age _____ Date of Birth _____ Weight _____

The following object are types of materials which may be hazardous or may interfere with the quality of the MRI examination. Please indicate if you have any of the following.

- | | | | | | |
|--------------------------|--------------------------|--|--------------------------|--------------------------|--|
| Yes | No | | Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | Cardiac Pacemaker | <input type="checkbox"/> | <input type="checkbox"/> | Heart valve |
| <input type="checkbox"/> | <input type="checkbox"/> | Aneurysm clip(s) | <input type="checkbox"/> | <input type="checkbox"/> | Ear implant |
| <input type="checkbox"/> | <input type="checkbox"/> | Implanted cardiac defibrillator | <input type="checkbox"/> | <input type="checkbox"/> | Penile prosthesis |
| <input type="checkbox"/> | <input type="checkbox"/> | Neurostimulator | <input type="checkbox"/> | <input type="checkbox"/> | Orbital or eye prosthesis |
| <input type="checkbox"/> | <input type="checkbox"/> | Hearing Aid | <input type="checkbox"/> | <input type="checkbox"/> | Any stents |
| <input type="checkbox"/> | <input type="checkbox"/> | History of kidney disease or ESRD | <input type="checkbox"/> | <input type="checkbox"/> | Vascular access port |
| <input type="checkbox"/> | <input type="checkbox"/> | Any chance of pregnancy | <input type="checkbox"/> | <input type="checkbox"/> | Intraventricular shunt |
| <input type="checkbox"/> | <input type="checkbox"/> | Implanted insulin pump/drug infusion device | <input type="checkbox"/> | <input type="checkbox"/> | History of cancer |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a reaction to contrast medium used for X-ray, CT or MRI? | <input type="checkbox"/> | <input type="checkbox"/> | Implanted orthopedic device (pins, rods, screws, nails, wires, plates) |
| <input type="checkbox"/> | <input type="checkbox"/> | Swan-Ganz catheter | <input type="checkbox"/> | <input type="checkbox"/> | History of high blood pressure or high cholesterol |
| <input type="checkbox"/> | <input type="checkbox"/> | History of diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Wire Mesh |
| <input type="checkbox"/> | <input type="checkbox"/> | Any mechanical or magnetic implant | <input type="checkbox"/> | <input type="checkbox"/> | Dentures/braces |
| <input type="checkbox"/> | <input type="checkbox"/> | History of seizure, or asthma | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been injured by a metallic foreign body? (e.g. bullet, metal in eyes from welding, etc.) |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you wearing any medicated skin patches? | | | |

PLEASE LIST ANY SURGICAL PROCEDURES THAT YOU HAVE EVER HAD:

PLEASE LIST ALL MEDICATIONS THAT YOU ARE PRESENTLY TAKING:

PLEASE LIST ANY ALLERGIES(INCLUDING MEDICATIONS):

Patient Signature _____

For Technologist Use Only:

Clinical History _____

Scan Area _____ Referring Md _____ # _____

Technologist Signature _____

Next Appointment _____ Film Status _____

CC _____ VIA _____ G _____ IVP _____

AT _____ LOT# _____ EXP _____

_____ IMAGES