

ImageCare

Name _____ Date _____

Height _____ Weight _____

Have you ever had an MRI before? YES _____ NO _____

If yes, where was it done? _____

Please give a brief summary of your medical problem as it pertains to this exam. If having pain, be specific as to whether it is on the right or left. _____

HAVE YOU EVER HAD OR DO YOU NOW HAVE:

| | |
|---|--|
| YES ___ NO ___ A piece of metal removed from your eye | YES ___ NO ___ Ear implant (i.e.cochlear, stapes) |
| YES ___ NO ___ Exposure to cutting/grinding metal | YES ___ NO ___ Retinal Tack |
| YES ___ NO ___ Shrapnel Injury | YES ___ NO ___ Eyelid Spring |
| YES ___ NO ___ Brain surgery | YES ___ NO ___ Penile implant/prosthesis |
| YES ___ NO ___ Aneurysm clips | YES ___ NO ___ Artificial Limb |
| YES ___ NO ___ Shunt | YES ___ NO ___ Implanted electronic device (i.e.pain pump bone stimulator, etc.) |
| YES ___ NO ___ Heart surgery | YES ___ NO ___ Implanted drug pump |
| YES ___ NO ___ Artificial Heart Valve | YES ___ NO ___ Insulin pump |
| YES ___ NO ___ Pacemaker | YES ___ NO ___ Any type of internal electrodes or wires |
| YES ___ NO ___ Defibrillator | YES ___ NO ___ Medication Patch |
| YES ___ NO ___ Stents, coils, filters-If so, when placed? _____ | YES ___ NO ___ Tissue Expander |
| YES ___ NO ___ Removable dental work | YES ___ NO ___ Bullets, Pellets, or BB's |
| YES ___ NO ___ Tattoo | YES ___ NO ___ Wig, Hair piece |
| YES ___ NO ___ Body Piercing | YES ___ NO ___ Hearing Aid |
| YES ___ NO ___ Any personal history of cancer? | YES ___ NO ___ Do you have Sickle Cell Anemia |
| YES ___ NO ___ Any personal history of kidney disease? | YES ___ NO ___ Are you claustrophobic? |
| YES ___ NO ___ Are you on dialysis? | <u>Females:</u> |
| YES ___ NO ___ Are you diabetic? | YES ___ NO ___ Any possibility of pregnancy? |
| YES ___ NO ___ Do you have high blood pressure? | Date of Last Menstrual Cycle _____ |
| | YES ___ NO ___ Breast Feeding |

Please list any allergies _____

Please list any surgeries with approximate dates: _____

*****PLEASE REMOVE JEWELRY, HAIRPINS, HEARING AIDS*****

-I attest that the above information is correct to the best of my knowledge. I have read and understand the entire contents of this form, and I have had the opportunity to ask questions regarding the information on this form.

PATIENT SIGNATURE

DATE

FOR MRI OFFICE USE ONLY

COMMENTS: _____

R.T. Signature _____ Date _____