

# MRI - Patient History Sheet



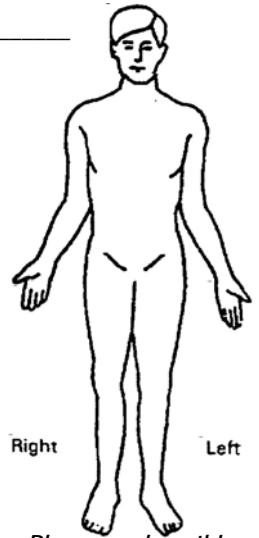
**WARNING:** Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure (i.e., MRI, MR angiography, functional MRI, MR spectroscopy). **Do not enter** the MR system room or MR environment if you have any question or concern regarding an implant, device, or object. Consult the MRI Technologist or Radiologist **BEFORE** entering the MR system room. The MR system magnet is **ALWAYS** on.

Date: \_\_\_/\_\_\_/\_\_\_ Patient Name: \_\_\_\_\_ XRAY #: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Please check 'yes' or 'no' if you have any of the following:

	Yes	No		Yes	No
Aneurysm clip(s)	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac pacemaker or pacemaker wires	<input type="checkbox"/>	<input type="checkbox"/>
Neurostimulator	<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy or possible pregnancy	<input type="checkbox"/>	<input type="checkbox"/>
Swanz-Ganz catheter	<input type="checkbox"/>	<input type="checkbox"/>	Implanted cardiac defibrillator	<input type="checkbox"/>	<input type="checkbox"/>
Hearing aid- <b>MUST REMOVE</b>	<input type="checkbox"/>	<input type="checkbox"/>	Implanted insulin or other infusion pump	<input type="checkbox"/>	<input type="checkbox"/>
Penile prosthesis	<input type="checkbox"/>	<input type="checkbox"/>	Implanted drug infusion device	<input type="checkbox"/>	<input type="checkbox"/>
Vascular access port	<input type="checkbox"/>	<input type="checkbox"/>	Any type of foreign body/shrapnel/or bullet/metal fragment	<input type="checkbox"/>	<input type="checkbox"/>
Spinal/Intraventricular shunt	<input type="checkbox"/>	<input type="checkbox"/>	Any type of implant held in place by a magnet	<input type="checkbox"/>	<input type="checkbox"/>
Artificial limb/joint	<input type="checkbox"/>	<input type="checkbox"/>	Any type of surgical clip or staple(s)	<input type="checkbox"/>	<input type="checkbox"/>
Dentures/Partials- <b>MUST REMOVE</b>	<input type="checkbox"/>	<input type="checkbox"/>	Bone growth stimulator	<input type="checkbox"/>	<input type="checkbox"/>
Wire Mesh Implant	<input type="checkbox"/>	<input type="checkbox"/>	History of working with sheet metal/welding	<input type="checkbox"/>	<input type="checkbox"/>
Heart valve prosthesis	<input type="checkbox"/>	<input type="checkbox"/>	Any type of ear implant	<input type="checkbox"/>	<input type="checkbox"/>
Biostimulator	<input type="checkbox"/>	<input type="checkbox"/>	Orbital/eye prosthesis	<input type="checkbox"/>	<input type="checkbox"/>
Tattoo or permanent makeup	<input type="checkbox"/>	<input type="checkbox"/>	Internal electrodes or wires	<input type="checkbox"/>	<input type="checkbox"/>
IUD, diaphragm, or pessary	<input type="checkbox"/>	<input type="checkbox"/>	Body piercing jewelry- <b>MUST REMOVE</b>	<input type="checkbox"/>	<input type="checkbox"/>
Radiation seeds or implants	<input type="checkbox"/>	<input type="checkbox"/>	Medication patch <b>MUST REMOVE</b>	<input type="checkbox"/>	<input type="checkbox"/>
Eyelid spring or wire	<input type="checkbox"/>	<input type="checkbox"/>	(Nicotine/Nitroglycerine/birth control)		
Tissue Expander (e.g., breast)	<input type="checkbox"/>	<input type="checkbox"/>	Breathing problem/motion disorder	<input type="checkbox"/>	<input type="checkbox"/>
<b>Claustrophobia</b>	<input type="checkbox"/>	<input type="checkbox"/>	Any electronic, mechanical/surgical implant	<input type="checkbox"/>	<input type="checkbox"/>
			Type _____ Model _____		



Please mark on this drawing the location of any implant or metals inside

Any type of intravascular coil, filter, or stent (e.g. Gianturco coil, Gunther IVC filter, Greenfield filter, heart stent)

Any implanted orthopedic item(s) (i.e., pins, rods, screws, nails, clips, plates, etc) Type \_\_\_\_\_



**IMPORTANT INSTRUCTIONS:** Before entering the MR environment or MR system room, you must remove all metallic objects including hearing aids, dentures, partial plates, keys, beeper, cell phone, eyeglasses, hair pins, barrettes, jewelry, body piercing jewelry, watch, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools, clothing with metal fasteners, & clothing with metallic threads. Please consult the MRI Technologist or Radiologist if you have any question or concern **BEFORE** you enter the MR system room.

NOTE: You may be advised or required to wear earplugs or other hearing protection during the MR procedure to prevent possible problems or hazards related to acoustic noise.

1. Have you had prior surgery or an operation (e.g., arthroscopy, endoscopy, etc.) of any kind? ! No ! Yes

If yes, please indicate the date and type of surgery:

Date \_\_\_/\_\_\_/\_\_\_ Type of surgery \_\_\_\_\_

Date \_\_\_/\_\_\_/\_\_\_ Type of surgery \_\_\_\_\_

2. Have you experienced any problem related to a previous MRI examination or MR procedure? ! No ! Yes

If yes, please describe: \_\_\_\_\_

3. Have you had an injury to the eye involving a metallic object or fragment (e.g., metallic slivers, shavings, foreign body, etc.)? ! No ! Yes

4. Are you allergic to any medications? If yes, please list: \_\_\_\_\_

5. Do you have a history of asthma, allergic reaction, respiratory disease, or reaction to a contrast medium or dye used for an MRI, CT, or X-ray examination? ! No ! Yes

9. Do you have anemia or any disease(s) that affects your blood, a history of renal (kidney) disease, or seizures? ! No ! Yes

If yes, please describe: \_\_\_\_\_

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 have had the opportunity to ask questions regarding the information on this form.

Signature of Person Completing Form: \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

Signature



**WARNING:** The MR system has a very strong magnetic field that may be hazardous to individuals entering the MR environment or MR system room if they have certain metallic, electronic, magnetic, or mechanical implants, devices, or objects. Therefore, all individuals are required to fill out this form BEFORE entering the MR environment or MR system room. Be advised, the MR system magnet is ALWAYS on.

**CONTRAST CONSENT**

A contrast agent has been developed to produce better pictures of the part of your body that is being examined. This contrast agent will be injected into your vein. In a small percentage of cases headaches or nausea are noted up to 24 hours following contrast administration. In a smaller percentage of cases, there may be more severe complications. These problems are usually recognized promptly and treated without difficulty. If there is any history of anemia, sickle cell anemia, or kidney disorder, these should be described to the technologist and radiologist.

**Female Patients:** If you are pregnant or breast feeding, please notify the technologist.

I consent and authorize \_\_\_\_\_ to perform a contrast injection for an MRI scan on me.

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

**CONSENT FOR MRI**

Magnetic resonance (MRI) procedures are unsafe for patients with certain biomedical implants, materials and devices such as defibrillators, pacemakers, cochlear implants and occasionally other surgically implanted devices. Please notify the technologist before your exam if you have a surgically implanted device.

I understand the nature of this examination and all questions concerning this examination were explained to my satisfaction. I understand that certain metal objects that may be in my body can be influenced by the magnetic field and their movement within my body may cause serious consequences. I understand that I may terminate this examination at any time and that the examination will be conducted by specially trained medical personnel.

I have been given an opportunity to ask questions about my condition, alternative diagnostic procedures, the potential risks involved, and I believe I have sufficient information to give this informed consent.

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

**PREGNANCY CONSENT**

For female patients:

- 1. Date of last menstrual period: \_\_\_\_/\_\_\_\_/\_\_\_\_ Post menopausal? ! No ! Yes
- 2. Are you pregnant or experiencing a late menstrual period? ! No ! Yes
- 3. Are you taking oral contraceptives or receiving hormonal treatment? ! No ! Yes
- 4. Are you taking any type of fertility medication or having fertility treatments? ! No ! Yes If yes, please describe \_\_\_\_\_
- 5. Are you currently breastfeeding? ! No ! Yes

While there have been no long-term studies and the safety of scanning pregnant patients has not been established, there does not seem to be any data suggesting deleterious outcomes from exposure of the developing fetus to MRI environments. An epidemiologic study of MRI technologists in the United States was reassuringly negative against any statistically significant elevations of spontaneous abortion rates, infertility, or premature delivery. There are no documented cases of MRI induced fetal anomalies. In fact, MRI is an accepted tool in assessing fetal anatomy in utero.

I understand that although there are no known risks, Magnetic Resonance Imaging (MRI) is performed after the first trimester of pregnancy only under special circumstances.

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

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 the form.

Patients Signature **X** \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**Reviewed by :**