

PERSONAL PATIENT INFORMATION

Patient Name: _____ Birthdate: ____/____/____
Last First M.I.

DO YOU HAVE A PACEMAKER? _____ IF YES, PLEASE SEE THE RECEPTIONIST.

Address: _____
Street City, State, Zip

Home Phone: _____ Other Phone: _____ SSN: _____ - _____ - _____

Employer: _____ Sex: M F

Referring Doctor: _____ Primary Care Doctor: _____

Can we send your primary doctor your results? _____ Any other doctor? _____

Primary Ins. Subscriber (if different from patient) Name: _____ Date of Birth: _____

Secondary Ins. Subscriber Name: _____ Date of Birth: _____

_____ Insurance _____ Workers Comp _____ Auto _____ Self

Some of the following items may be hazardous to your safety or may interfere with the MRI study. Please check any item that may pertain to you.

YES NO

<input type="checkbox"/>	<input type="checkbox"/>	Have you ever been a machinist, welder or sheet metal worker?
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever been hit in the face or eye with a piece of metal (including metal shavings, bullets or BBs)?
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a piece of metal removed from your eye?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have a history of cancer? If yes: _____
<input type="checkbox"/>	<input type="checkbox"/>	Are you pregnant, possibly pregnant, or breast feeding?
<input type="checkbox"/>	<input type="checkbox"/>	Are you allergic to any medications? If yes, list: _____
<input type="checkbox"/>	<input type="checkbox"/>	Do you have claustrophobia?

Do you have the following items on your person today?

YES NO

<input type="checkbox"/>	<input type="checkbox"/>	Cardiac Pacemaker or Defibrillator
<input type="checkbox"/>	<input type="checkbox"/>	Medication Patch
<input type="checkbox"/>	<input type="checkbox"/>	Electrical stimulator for nerves or bones
<input type="checkbox"/>	<input type="checkbox"/>	Implanted Drug Infusion Pump
<input type="checkbox"/>	<input type="checkbox"/>	Aneurysm, Carotid or Surgical Clips
<input type="checkbox"/>	<input type="checkbox"/>	Artificial Limb or Joint or Implant
<input type="checkbox"/>	<input type="checkbox"/>	Artificial Heart Valves or Heart Stents
<input type="checkbox"/>	<input type="checkbox"/>	Hearing Aid, removable or implanted

YES NO

<input type="checkbox"/>	<input type="checkbox"/>	Shunt or Stent - Present card to receptionist.
<input type="checkbox"/>	<input type="checkbox"/>	Metal Screws or Plates
<input type="checkbox"/>	<input type="checkbox"/>	Dentures, partials, retainers (removable)
<input type="checkbox"/>	<input type="checkbox"/>	Wires, Sutures or Staples
<input type="checkbox"/>	<input type="checkbox"/>	Shrapnel or Bullets, BBs or pellets
<input type="checkbox"/>	<input type="checkbox"/>	Coil or Filter
<input type="checkbox"/>	<input type="checkbox"/>	Tattoos less than 1 month old
<input type="checkbox"/>	<input type="checkbox"/>	Body Piercing (other than ears)

Please list your approximate weight: _____ lbs.

I attest that the above information is correct to the best of my knowledge. I have read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and the MRI procedure that I am to undergo. I understand that the facility is not responsible for valuables and personal property brought to the facility.

Signature: _____ Date: _____

CONTRAST SCREENING AND CONSENT

Your physician may deem it necessary for you to have an IV injection of a contrast agent containing gadolinium to improve the quality of your MR examination. Although gadolinium contrast agents have been used safely in millions of patients, minor reactions (principally headache or nausea), and serious or life threatening reactions may occur.

Do you have asthma? YES NO Do you have diabetes? YES NO
 Do you have renal disease? YES NO Do you have vascular thrombosis? YES NO
 Have you had an organ transplant? YES NO Vascular or venous surgery? YES NO
Have you had an MRI with contrast before? YES NO **Did you have a reaction?** YES NO

I have read and understand the above information, and have had my questions answered. I agree to have the MRI procedure and injection of contrast if deemed necessary.

Signature: _____ Date: _____

PATIENT NAME: _____

What are your primary symptoms? _____

Do you have numbness or tingling? _____ Yes _____ No
_____ Arms _____ Legs _____ Face _____ Right Side _____ Left Side _____ Both Sides

When did symptoms start? _____

Are these symptoms because of an injury? _____ Yes _____ No

Briefly explain injury _____

Have you had any of the following on the body part that we are scanning?
_____ X-Rays _____ CT Scan _____ Ultrasound

Have you ever had surgery on the body part that we are scanning today? _____ Yes _____ No
If yes, list type of procedure, doctor performing and where procedure was performed:

Do you have any other medical conditions that we should know about?

If you are here for a brain/head MRI, please also answer the following questions. Thank you.

Have you ever had a head injury? _____ If so, when? _____

Do you have headaches? _____ Difficulty walking? _____ Seizures? _____

Left or Right sided weakness? (Please specify) _____

Have you had surgery in your brain region? _____

Chemotherapy? _____ Radiation therapy? _____

If yes, please describe your treatment. _____

Patient Signature:

Date: