PREMIER
MOUNTAIN IMAGING CENTER

MRI History

PLEASE PRINT: **Date:**____________________ ☐ M ☐ F

Name (last, first):____**Date of Birth**:____________

Referring Physician:____**Height**:_______ **Weight**__ ____

PATIENT HISTORY

Reason you are here today? Please list the problem, the area(s) experiencing the problem and when it started)____

____

Have you had any surgery in the area being scanned? ☐ Y ☐ N

Type/date:____

Any history of trauma or injury in the area we are scanning today? ☐ Y ☐ N

Type/date:____

Do you have a history of cancer? ☐ Y ☐ N

Type/date:____

Any prior imaging/scans on the body part we are scanning today? ☐ Y ☐ N

Type/date/facility name:____

Do you have any food or drug allergies? ☐ Y ☐ N

List all:____

Pre-medicated specifically for this study today? ☐ Y ☐ N

Medication Name(s):___________________________________Time/date of last dose___________

Physician Name who prescribed:____

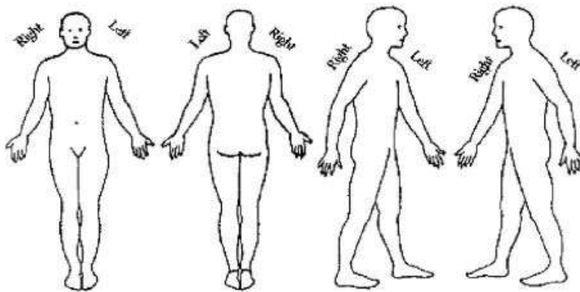
Have you ever had metal in your eye or removed from your eyes? ☐ Y ☐ N

FEMALE ONLY: **Is there a possibility of pregnancy?** ☐ Y ☐ N

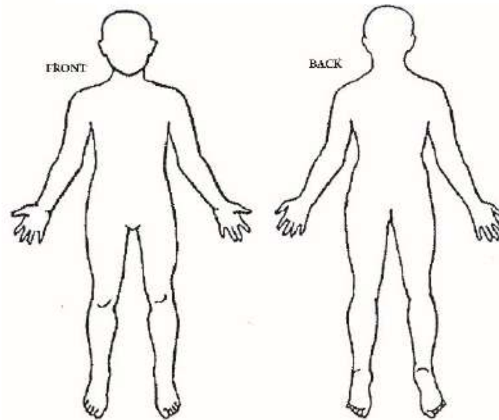
Last Menstrual Cycle:_____________________________How Far Along?________________________

PAIN

Please mark the areas of your body where you feel pain/numbness/tingling/weakness



Please mark on the figure(s) below the location of implant or metal inside of or on your body



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MRI Screening

Do you have any of the following: (Please Circle)

Aneurysm clip(s)
IUD, diaphragm, or pessary
Cardiac pacemaker
Artificial or prosthetic limb
Implanted cardioverter defibrillator (ICD)
Radiation seeds or implants
Electronic implant or device
Swan-Ganz or thermodilution catheter
Magnetically-activated implant or device
Medication patch (nicotine, nitroglycerine, etc)
Neurostimulation system
Any metallic fragment or foreign body
Spinal cord stimulator
Wire mesh implant
Internal electrodes or wires
Tissue expander (e.g. breast)
Bone growth/bone fusion stimulator
Surgical staples, clips, metallic sutures
Cochlear, otologic, or other ear implant
Joint replacement (hip, knee, etc)
Insulin or other infusion pump
Bone/joint pin, screw, nail, wire, plate, etc.
Implanted drug infusion device
Dentures, implants or partial plates
Any type of prosthesis (eye, penile, etc)
Tattoo, permanent makeup, magnetic lashes
Heart valve prosthesis
Body piercing jewelry
Eyelid spring or wire
Hearing aid (remove before entering MR room)
Metallic stent, filter, or coil
Shunt (spinal or intraventricular)
Breathing problems or motion disorder
Vascular access port and/or catheter
Claustrophobia
Other implant:__________

Make:_________ Model:___________ Implant Date:__________
Make:_________ Model:___________ Implant Date:__________

WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with MR procedure (i.e., MRI, MR angiography).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. Before entering the MRI environment or MRI 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, paper clips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools, clothing with metal fasteners and clothing with metallic threads. Safety risks from Radiofrequency (RF) waves include potential tissue heating and burns. Alert the scanner operator immediately if warming occurs. Please note that some warming is normal but you should never be uncomfortable. **Important Note:** The noise generated by scanning may reach a level in the scan room and in the bore of the magnet that can result in temporary (and occasionally) permanent hearing loss. Any patient who undergoes an MRI, as well as anyone in Zone 4 during a Scan, **MUST** wear hearing protection. Your exam may be monitored for quality assurance.

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 regarding the MRI procedure I am about to undergo.

Signature of person completing form:_________________________________**Date:**___________

Form Completed by: ☐ **Patient** ☐ **Relative** ☐ **Nurse/Caregiver**

Printed Name:____

Office Use Only:

Technologist/Credentials:______________________________________Date:______________