List MRI Information Sheet

Patient Name:	Date of Birth:	Age:
Weight: Height:	Next Appt with Physician about these results:	

What are your current symptoms?	
How long have you had this problem?	
Have you had other imaging studies for your CURRENT problem? (MR,CT,US, X-rays etc)	❑ Yes ❑ No If yes, list type of study and facility:
Any injury related to the area being imaged? Date of Injury: _____	❑ Yes ❑ No If Yes, explain injury:
List ALL surgeries in your lifetime?	
Have you ever been diagnosed with cancer? Have you had Chemotherapy? Have you had radiation treatment?	❑ Yes ❑ No If yes, what type: ❑ Yes ❑ No If yes, when: ❑ Yes ❑ No If yes, when:
Is patient pregnant? Is patient breastfeeding?	❑ Yes ❑ No ❑ Yes ❑ No Last Menstrual Period:

Allergies to Medications & Reactions: □ NONE □ Iodine □ Sulfa □ Penicillin □ Latex □ MR Contrast

□ Other_____

□ Reactions_____

Current Medications:_____

Do you have or have you had any of the following:

Aneurysm clips	❑ Yes ❑ No	Hearing Aids	❑ Yes ❑ No	Metal fragments in eye, head, skin	❑ Yes ❑ No
Neurostimulator	❑ Yes ❑ No	Heart Valve implant	❑ Yes ❑ No	Any surgery in the last 8 weeks	❑ Yes ❑ No
Tissue Expander	❑ Yes ❑ No	Implanted Pump	❑ Yes ❑ No	Metal Worker/ Welder	❑ Yes ❑ No
Pacemaker/ICD	❑ Yes ❑ No	Seizures	❑ Yes ❑ No	Injury from Shrapnel/BBs	❑ Yes ❑ No
Stent	❑ Yes ❑ No	Any body piercings	❑ Yes ❑ No	Dentures, partial plate or braces	❑ Yes ❑ No
Diabetes	❑ Yes ❑ No	Kidney Disease	❑ Yes ❑ No	Venous Access/Port Device	❑ Yes ❑ No
Ear/Eye implant	❑ Yes ❑ No	Any type prosthesis	❑ Yes ❑ No	Wearing Medication Patch	❑ Yes ❑ No
Iron Infusion	❑ Yes ❑ No	UV Tatoo	❑ Yes ❑ No	Inspiresleep implant	❑ Yes ❑ No