

Patient Name: \_\_\_\_\_ Date \_\_\_\_\_

Weight: \_\_\_\_\_ Height: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex (M/F) : \_\_\_\_\_

**PLEASE ANSWER ALL QUESTIONS** (Circle response for YES/NO questions)Describe your symptoms (*i.e., pain, numbness, headache, etc.*):

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Were you injured in the area being examined? YES / NO

If YES, please explain how you were injured: (*i.e., fall, accident, lifting, etc.*)

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Have you had surgery in the area being examined? YES / NO If YES, when? (*Approximate year*) \_\_\_\_\_

Is it possible you may have metal in your eyes? YES / NO

Have you ever had cancer? YES / NO If YES, what type? \_\_\_\_\_

Do you have any blood disorders, renal disease, or seizures? YES / NO

If YES, please describe: \_\_\_\_\_

Have you ever had an MRI? YES / NO If YES, on what body part? \_\_\_\_\_

Do you have any drug allergies? YES / NO

If YES, please list: \_\_\_\_\_

Do you smoke? YES / NO

Are you diabetic? YES / NO

Are you pregnant or experiencing a late period? YES / NO

Are you breast feeding? YES / NO

Please list all the studies you may have had recently that might pertain to the body part being examined today:  
(*i.e., X-rays, MRIs, Cat Scans, etc.*)

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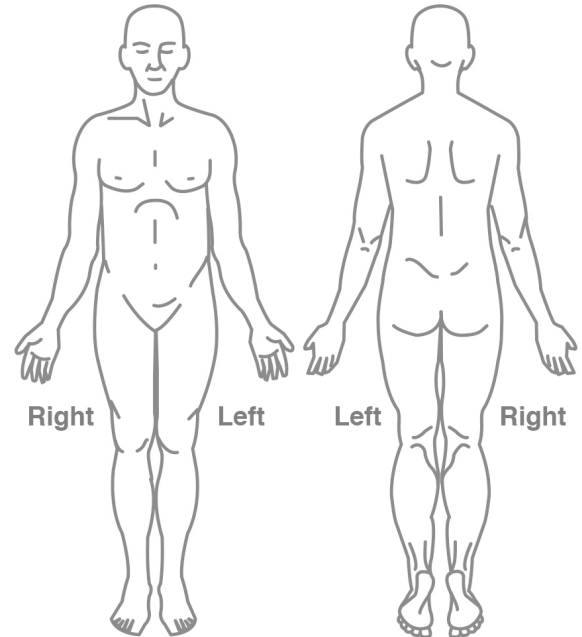


**WARNING:** Certain implants, devices, or objects may be hazardous to you and or may interfere with the MR procedure (i.e., MRI, MR angiography, functional MRI, MR spectroscopy). **DO NOT ENTER** the MR system room or MR environment if you have any question or concern regarding an implant, device, or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

Please circle YES or NO if you have any of the following:

Aneurysm clip(s)	YES / NO
Cardiac pacemaker	YES / NO
Implanted cardioverter defibrillator (ICD)	YES / NO
Electronic implant or device	YES / NO
Magnetically-activated implant or device	YES / NO
Neurostimulation system	YES / NO
Spinal cord stimulator	YES / NO
Internal electrodes or wires	YES / NO
Bone growth/bone fusion stimulator	YES / NO
Cochlear, otologic, or other ear implant	YES / NO
Insulin or other infusion pump	YES / NO
Implanted drug infusion device	YES / NO
Any type of prosthesis (eye, penile, etc.)	YES / NO
Heart valve prosthesis	YES / NO
Eyelid spring or wire	YES / NO
Artificial or prosthetic limb	YES / NO
Metallic stent, filter, or coil	YES / NO
Shunt (spinal or intraventricular)	YES / NO
Vascular access port and/or catheter	YES / NO
Radiation seeds or implants	YES / NO
Swan-Ganz or thermodilution catheter	YES / NO
Medication patch (Nicotine, Nitroglycerine)	YES / NO
Any metallic fragment or foreign body	YES / NO
Wire mesh implant	YES / NO
Tissue expander (i.e., breast)	YES / NO
Surgical staples, clips, or metallic sutures	YES / NO
Joint replacement (hip, knee, etc.)	YES / NO
Bone/joint pin, screw, nail, wire, plate, etc.	YES / NO
IUD, diaphragm, or pessary	YES / NO
Dentures or partial plates	YES / NO
Tattoo or permanent makeup	YES / NO
Body piercing jewelry	YES / NO
Hearing aid (remove before entering MR system room)	YES / NO
Other implant:	YES / NO
Breathing problem or motion disorder	YES / NO
Claustrophobia	YES / NO

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



### IMPORTANT INSTRUCTIONS

**Before entering the MR environment/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 and clothing with metallic threads.

**Please consult the MRI Radiologic Technologist if you have any questions or concerns BEFORE you enter the MR system room.**

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

I attest that the above information is correct to the best of my knowledge. I read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and regarding the MR procedure that I am about to undergo.

Form Completed By (Please print name): \_\_\_\_\_

Relationship to Patient:  Patient  Relative  Nurse  Other \_\_\_\_\_

Signature of Responsible Party: \_\_\_\_\_ Date \_\_\_\_\_

**FOR INTERNAL USE ONLY** Form Reviewed By:  MRI Tech  Radiologist  Other \_\_\_\_\_

Approved by (signature) : \_\_\_\_\_