

# MRI HISTORY

Patient Name (Printed): \_\_\_\_\_ Birth Date: \_\_\_\_\_

Acct.#: \_\_\_\_\_

**THE FOLLOWING ITEMS MAY BE HAZARDOUS OR INTERFERE WITH MRI.  
PLEASE ANSWER CAREFULLY. DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING:**

- Yes  No Pacemaker/Pacemaker wires or Heart valve/Heart surgery/Stent?
  - Yes  No Implanted cardiac defibrillator?
  - Yes  No Brain aneurysm clip/Other brain surgery?
  - Yes  No Ear surgery/Cochlear Implant/Inner ear prosthesis/Hearing aids?
  - Yes  No Vascular access port/Central venous catheter?
  - Yes  No Metal slivers in eye/History of welding or metal grinding?
  - Yes  No Eye surgery/Ocular implants?
  - Yes  No Shrapnel/Bullet fragments/BBs/Other metal foreign body?
  - Yes  No Neurostimulator/TENS/muscle stimulator (pelvic floor, etc)?
  - Yes  No Removable dentures or partials?
  - Yes  No Diaphragm/IUD?
  - Yes  No Penile implant/Pessary/metal mesh?
  - Yes  No IVC filter/Joint replacement/metal plates, surgical clips, staples or screws, orthopedic implants?
  - Yes  No Tattoos/Piercing with metal jewelry/Permanent makeup?
  - Yes  No Do you have Diabetes or Insulin pump/Pain pump?
  - Yes  No Do you have a history of cancer? If so, what type? \_\_\_\_\_
  - Yes  No Do you have a history of kidney (renal) disease, including kidney disease secondary to collagen vascular disease (Lupus, Scleroderma, etc.) or multiple myeloma?
  - Yes  No Do you have a history of kidney failure, kidney tumor, kidney surgery, kidney transplant, or renal dialysis?
  - Yes  No Are you wearing a transdermal patch (e.g., Nicotine patch)?
  - Yes  No Any type of intravascular coil, filter or stent?
  - Yes  No Any type of electronic, mechanical or magnetic implant?
  - Yes  No Are you breast feeding?
  - Yes  No Are you pregnant or suspect you might be pregnant? Date of last menstrual period \_\_\_\_\_
  - Yes  No Have you had lumbar spine surgery?
  - Yes  No Do you have active gout?
  - Yes  No Artificial limb/prosthesis?
  - Yes  No Do you have high blood pressure?
  - Yes  No Do you have any allergies including drug allergies?
- If yes, what are you allergic to: \_\_\_\_\_

**DESCRIBE YOUR SYMPTOMS OR THE REASON YOU ARE HAVING TODAY'S MRI:**

\_\_\_\_\_

**HAVE YOU HAD A PREVIOUS X-RAY, CT OR MRI OF THE AREA BEING SCANNED TODAY?**

If yes, list what was done and where it was performed: \_\_\_\_\_

\_\_\_\_\_

I understand the above information and I have answered the questions to the best of my knowledge. I have had the opportunity to ask questions about the information on this form that I did not understand.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date



**OPTIMAL IMAGING**  
St. Vincent's HealthCare

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