Regional Medical Imaging
MRI Patient History Form

Clinical Details: This Side - Staff Use Only		
Contrast Name:		Lot #:
Creat:	Bottle Size:	Tech Initials:
eGFR:	Used:	History:

Patient History

Today's Date: **Referring Physician:**

Patient Name: **DOB:** **Weight:** **Height:**

If Patient is a minor or nursing home patient-Name of accompanying adult and relationship to patient:

Order States:

Patient States:

Surgical History of the area being examined & Date(s)

Have you ever been diagnosed with Cancer? Type & Date(s)

Treatment Type (Chemo/Radiation) & Date(s)

Previous X-Ray, CT, MRI, or US study of area being examined?

Smoking History-Lung Screening			
☐ None Provided	☐ Current	Packs per day:	Number of years smoked:
☐ Never	☐ Past	Quit - How long ago?	History of Lung cancer?

Patient Name: _____ Date of Birth: _____

WARNING: Certain implants, devices, or objects may be hazardous to you in the MR environment or MR system room. Do not enter the MR environment of MR system room if you have any questions or concerns regarding an implant, device, or object.
Be Advised, the MR system magnet is ALWAYS on!

Please indicate if you have any of the following:					
Yes	No		Yes	No	
☐	☐	**Pacemaker/defibrillator**	☐	☐	**Implanted drug pump**
☐	☐	**Aneurysm clips or coils**	☐	☐	**Insulin Pump**
☐	☐	**Electronic implant or device**	☐	☐	**Loop recorder**
☐	☐	**Brain, eye, ear surgery**	☐	☐	**Open heart surgery**
☐	☐	**Cochlear Implant or middle ear implant**	☐	☐	**Any metallic fragment or foreign body**
☐	☐	**Metal removed from eyes**	**Cleared by:**		
☐	☐	**Internal Stimulator**	**Type:**		
☐	☐	**Artificial or prosthetic limb**	**Type:**		
☐	☐	**Any type or Prosthesis or implant**	**Type:**		
☐	☐	**Other implant**	**Type:**		

Medications: _____

_____

_____

Allergies: _____

Clinical Information:					
Yes	No		Yes	No	
☐	☐	**Chance of Pregnancy** **Last Menstrual Period:**	☐	☐	**Breastfeeding** **If yes: recommend 24 hour discard**
☐	☐	**Renal failure**	☐	☐	**Diabetes**
☐	☐	**Single Kidney/Kidney Transplant**	☐	☐	**Blood Born Contagious Diseases**
☐	☐	**Dialysis**	☐	☐	**Seizure History**
☐	☐	**High Blood Pressure**	☐	☐	**Anemia/Sickle Cell Anemia**
☐	☐	**Stroke/TIA**	☐	☐	**Latex Allergy**
☐	☐	**Asthma/Breathing Disorders**			
☐	☐	**Previous Contrast Reaction**	**Name of Dye**		**Type of Reaction**

Contrast Consent:

I attest that the above information is correct to the best of my knowledge. I have read and understand the entire contents of this form and have had the opportunity to ask questions regarding the information on this form.
I GIVE CONSENT TO HAVE CONTRAST INJECTED IF REQUIRED, FOR MY EXAM.

Signature of Person Completing Form: _____ Date: _____