

**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**

<input type="checkbox"/> None Provided	<input type="checkbox"/> Current	Packs per day:	Number of years smoked:
<input type="checkbox"/> Never	<input type="checkbox"/> 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	
<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker/defibrillator	<input type="checkbox"/>	<input type="checkbox"/>	Implanted drug pump
<input type="checkbox"/>	<input type="checkbox"/>	Aneurysm clips or coils	<input type="checkbox"/>	<input type="checkbox"/>	Insulin Pump
<input type="checkbox"/>	<input type="checkbox"/>	Electronic implant or device	<input type="checkbox"/>	<input type="checkbox"/>	Loop recorder
<input type="checkbox"/>	<input type="checkbox"/>	Brain, eye, ear surgery	<input type="checkbox"/>	<input type="checkbox"/>	Open heart surgery
<input type="checkbox"/>	<input type="checkbox"/>	Cochlear Implant or middle ear implant	<input type="checkbox"/>	<input type="checkbox"/>	Any metallic fragment or foreign body
<input type="checkbox"/>	<input type="checkbox"/>	Metal removed from eyes	Cleared by:		
<input type="checkbox"/>	<input type="checkbox"/>	Internal Stimulator	Type:		
<input type="checkbox"/>	<input type="checkbox"/>	Artificial or prosthetic limb	Type:		
<input type="checkbox"/>	<input type="checkbox"/>	Any type or Prosthesis or implant	Type:		
<input type="checkbox"/>	<input type="checkbox"/>	Other implant	Type:		

**Medications:**

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**Allergies:**

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**Clinical Information:**

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Chance of Pregnancy Last Menstrual Period:	<input type="checkbox"/>	<input type="checkbox"/>	Breastfeeding If yes: recommend 24 hour discard
<input type="checkbox"/>	<input type="checkbox"/>	Renal failure	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Single Kidney/Kidney Transplant	<input type="checkbox"/>	<input type="checkbox"/>	Blood Born Contagious Diseases
<input type="checkbox"/>	<input type="checkbox"/>	Dialysis	<input type="checkbox"/>	<input type="checkbox"/>	Seizure History
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Anemia/Sickle Cell Anemia
<input type="checkbox"/>	<input type="checkbox"/>	Stroke/TIA	<input type="checkbox"/>	<input type="checkbox"/>	Latex Allergy
<input type="checkbox"/>	<input type="checkbox"/>	Asthma/Breathing Disorders			
<input type="checkbox"/>	<input type="checkbox"/>	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: \_\_\_\_\_