MRI – MEDICAL / SURGICAL PATIENT HISTORY SHEET

MIMA#: _____ Patient Name: _____ DOB: _____ Age: ____

Male/Female: _____ Height: _____ Weight: _____ Referring Physician: _____

Exam Date:_____ Exam Time:_____ Type of Exam:_____

PLEASE FILL OUT ALL QUESTIONS EXCEPT FOR SHADED AREAS

Y N Are you **claustrophobic**? Y N Did you take any sedation for this scan today?

Have you had or do you have any of the following:

Y N **Cardiac Pacemaker** or **Defibrillator?**
Y N **Brain Aneurysm Clip?**
Y N **Brain surgery?** Please explain: _____
Y N **Heart Surgery**? Please explain: _____
Y N **Vascular/Arterial repair**? Please explain: _____
Y N **Eye implants**? Please explain: _____
Y N **Ear implants**? Please explain: _____
Y N **Electronic Implants, Stimulators or Pumps including Penile Implants**? Please explain: ____
_____
Y N **Metal fragments in your eyes**? Please explain: _____
Y N **Medication Patch**? Please explain: _____
Y N **Body Piercing** or **Tattoos**? Location: _____
Y N **Kidney Problems**? Please explain:_____
Y N Do you have **Removable Dental Work**?
Y N Do you have **Hearing Aids**?
Y N Personal history of **Cancer**? (Not family history): Please Explain: _____
_____
_____
Y N **Radiation Therapy** or **Chemo Therapy**? Please Explain: _____
Y N Do you have a history of **Sickle Cell**?
Y N Do you have a history of **Seizures**?
Y N Do you have a history of **MS**?

Please list ALL prior surgeries:_____
_____

What is your **clinical history** for your exam **today**? _____
_____
_____

MRI PROTOCOL – Patients over 40 years old: **GFR**: _____ **Creatinine**:_____ **Date Drawn**:_____

Contrast – YES or NO_____mL Omniscan (GFR >90mL) Lot#:_____ Exp:_____
_____mL Multihance (GFR between 60-89mL) Lot#: _____ Exp:_____
_____mL Multihance (GFR between 30-60mL)
OK BY NEPHROLOGIST OR RADIOLOGIST:_____MD
Lot#: _____ Exp: _____

Female Patients:Date of last menstrual period: _____ Post Menopausal: Yes or No
Y N Any **chance** of pregnancy: Y N Are you **currently** breastfeeding?

Y N Prior MRI or CT When: _____ Where: _____
Y N Plain X-Rays of Region of Interest When: _____ Where: _____

I attest that the above information is correct to the best of my knowledge. I have been given the opportunity to ask questions regarding the information on this form as well as the MRI procedure that I am about to undergo.

Patient Signature:_____ **Date**: _____

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Screening Technologist:

_____

Technologist Performing Exam:

Implant:

Manufacturer

_____

Serial Number:

Date of Surgery:

_____

Allergies:

_____
_____
_____
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