

Today's Date _____ Referring Doctor _____

Name _____ DOB _____ Age _____ Wt. _____

Your Symptoms/Reason for this Exam:

Surgical History _____

History of Cancer? _____

Have you had a MRI before? NO YES (if yes, please detail below)

Type _____ Date _____ Location _____

The following may be dangerous or interfere with your MRI.

Females: Any chance of pregnancy? YES NO LMP _____ Breastfeeding? Y N

Surgery or procedure in the last 6 weeks? YES NO

Do you work with metals (grinding, polishing, cutting)? YES NO

Cardiac pacemaker, defibrillator YES NO

Artificial heart valves YES NO

Cochlear implants YES NO

Aneurysm clips YES NO

Intravascular coil, filter, port, catheter YES NO

Implants – infusion device, pump, eye, ear, joint, mesh, penile YES NO

Wearing clothing with Dri-weave, Dri-fit, or Wicking fabric? YES NO

Metal in body – Shrapnel, bullets YES NO

Other device in body - IUD, pin, screw, clip, rod YES NO

Other _____

Patient Signature _____ Date _____

Tech comments _____

Reviewed by Tech (Signature) _____ Date _____

Translator _____ Translator Signature _____