Patient Sticker

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Chesterfield Imaging
HCAVa
AN HCA AFFILIATE

MRI PATIENT MEDICAL HISTORY

Please read carefully. Complete FRONT & BACK in its ENTIRETY

Weight: _____________

Reason for Today's MRI: ____

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Do you have any of the following?

If you answer YES, please provide detail on bottom &/or back of this form

	YES	NO
An implanted pacemaker or defibrillator?		
Any aneurysm clips in your brain?		
Any cochlear implants from inner ear surgery? (hearing aids)		
Any implanted electrical devices? (pain pump, neurostimulator, etc.)		
Any metallic implants in your body?		
Any history of an eye injury involving a metallic object? (metallic slivers, shavings, foreign body, etc.)		
Other surgical or medical procedures? LIST BELOW		

Do you have symptoms or PERSONAL history of?

			YES	NO		YES	NO
Arm Pain	LT	RT			Dizziness		
Arm Weakness	LT	RT			Headaches		
Arm Numbness	LT	RT			Stroke		
Leg Pain	LT	RT			Seizures		
Leg Weakness	LT	RT			Kidney Disease		
Leg Numbness	LT	RT			Diabetes		
Visual Problems	LT	RT			High Blood Pressure		
Hearing Problems	LT	RT			Liver Transplant		
Neck Mass	LT	RT			Cancer		
Neck Pain	LT	RT			Chemotherapy		
Speech Problems					Radiation Therapy		
Balance Problems					Other:		

Please indicate any previous surgery:

Part	Date	Part	Date	Part	Date
Brain		Heart		Shoulder LT RT	
C. Spine		Uterus/Ovaries		Knee LT RT	
T. Spine		Gall Bladder		Hip LT RT	
L. Spine		Other:___________		Foot/Ankle LT RT	

Is there a possibility that you are pregnant? YES / NO Are you breast feeding? YES / NO

Have you had a previous MRI? YES / NO Where? ______________________________When?_____________

OVER

Chesterfield Imaging
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MRI PATIENT MEDICAL HISTORY

Place all personal belongings in locker provided.
Remove all jewelry, metallic objects, and other personal items before procedure.

Do you have? (Please Check Appropriate Box)	**YES**	**NO**
Claustrophobia		
Cardiac Pacemaker		
Cardiac Defibrillator		
Aneurysm Clips		
Neurostimulator		
Medication Patch on your skin		
Ear/Cochlear Implants		
Surgery in the last 6 weeks		
Implanted Drug Infusion Device/ Pain Pump		

Do you have? (Please Check Appropriate Box)	**YES**	**NO**
Intravascular Coil/Filter/Stent		
Breast Tissue Expanders		
Penile Prosthesis		
Injury to Eye		
Implanted Orthopedic items		
Foreign Body/Shrapnel/Bullet		
Any other Metal Objects on your body?		
Any Questions about the MRI Safety Requirements?		
Other:		

IMPORTANT INSTRUCTIONS

Before entering the MR environment or MR system room, you must remove all metallic objects including hearing aids, dentures, partial plates, keys, beeper, cellphone, eyeglasses, hair pins, barrettes, jewelry, body piercing jewelry, watch, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools, clothing with metal fasteners, & clothing with metallic threads.

Please consult the MRI Technologist if you have any question or concern BEFORE you enter the MRI suite.

NOTE: You may be required to wear earplugs or other hearing protection during the MRI procedure to prevent possible problems or hazards related to acoustic noise.

I have read and completed the above questions on the MRI Patient Medical History & Safety Screening Form. I have been provided the opportunity to ask any questions I may have. I verify this by signing below.

_______________________________________ _____________________________

Patient or Authorized Representative Date

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If not patient, relationship to patient

FOR TECHNOLOGIST USE ONLY

By signing below, I acknowledge the following:

1. I have reviewed the above information on MRI Medical History form with the patient in its entirety.
2. I provided the patient an opportunity to ask any questions he/she may have.

Reviewed by: ____________________________________ Title: MRI Technologist

Signature: ______________________________________ Date: ________________