

Patient Sticker



# MRI PATIENT MEDICAL HISTORY

Please read carefully. Complete **FRONT & BACK** in its ENTIRETY

Weight: \_\_\_\_\_

Reason for Today's MRI: \_\_\_\_\_

## 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



## 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

\_\_\_\_\_  
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: \_\_\_\_\_