The Imaging Center
At Wolf River

MRI HISTORY FORM

Patient Name: ______________________________

DOB: ____________ Age: ____________ Height: ____________ Current weight: ____________

Have you had a previous imaging study related to this problem? □ **Yes** □ **No**

If yes. What exam? □ **CT** □ **MRI** □ **Ultrasound** □ **X-ray** □ **Other** What Facility? ____________

PERSONAL HISTORY Please indicate if you have any of the following:

□ **Yes** □ **No** Swan-Ganz or thermodilution catheter
□ **Yes** □ **No** Cardiac Pacemaker
□ **Yes** □ **No** Implanted Cardioverter defibrillator (ICD)
□ **Yes** □ **No** Aneurysm Clip(s)
□ **Yes** □ **No** Eyelid spring or wire
□ **Yes** □ **No** Heart valve prosthesis
□ **Yes** □ **No** Neuro or Spinal Cord Stimulator
□ **Yes** □ **No** Internal electrodes or wires
□ **Yes** □ **No** Bone growth / Bone Stimulator
□ **Yes** □ **No** Cochlear, otologic, or other ear implant
□ **Yes** □ **No** Implanted drug/insulin infusion device
□ **Yes** □ **No** Joint replacement (hip, knee, etc.)
□ **Yes** □ **No** Bone/joint pin, screw, nail, wire, plate, etc.)
□ **Yes** □ **No** Any other implant: ____________

□ **Yes** □ **No** Shunt (spinal or ventricular)
□ **Yes** □ **No** Tissue expander (e.g. breast)
□ **Yes** □ **No** Any type of prosthesis (limb, eye, penile, etc)
□ **Yes** □ **No** Metallic Stent, filter, or coil
□ **Yes** □ **No** IUD, diaphragm, or pessary
□ **Yes** □ **No** Wire mesh implant Surgical staples, clips, or metallic sutures
□ **Yes** □ **No** Medication Patch (Nicotine, Nitroglycerine)
□ **Yes** □ **No** Tattoo of permanent make-up
□ **Yes** □ **No** Dentures or partial plates
□ **Yes** □ **No** Body piercing jewelry
□ **Yes** □ **No** Hearing Aid
□ **Yes** □ **No** Any metallic fragment or shavings, BB, shrapnel or foreign body (including eye injuries)

PERSONAL HISTORY

Have you ever had a previous allergic reaction to injected MRI contrast □ **Yes** □ **No**

If yes, explain: ______________________________

□ **Yes** □ **No** Seizure Disorder
□ **Yes** □ **No** Asthma
□ **Yes** □ **No** Diabetes
□ **Yes** □ **No** Liver Disease

□ **Yes** □ **No** High Blood Pressure
□ **Yes** □ **No** Kidney Disease/ Kidney Failure
□ **Yes** □ **No** Dialysis
□ **Yes** □ **No** Heart or Blood Disease

□ **Yes** □ **No** Allergies If yes, please specify: ____________
□ **Yes** □ **No** Surgeries If yes, please specify: ____________
□ **Yes** □ **No** Cancer If yes, please specify: ____________

FEMALE PATIENTS ONLY

Some imaging procedures are contra-indicated (not recommended) for patients who may be pregnant. If you may be pregnant, please notify one of our team members. By my signature below, I acknowledge that I have read and understand this statement and state that I am not pregnant and there is no chance that I may be pregnant.

Are you breastfeeding? □ **Yes** □ **No** Date of last period: ____________

ACKNOWLEDGEMENT

I attest that the above information is correct to the best of my knowledge. I read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and regarding the MR procedure that I am about to undergo. If I am to have intravenous contrast with my MRI, I have been informed of the risks of possible allergic reactions and that patients with kidney disease can suffer serious effects by receiving gadolinium based contrast agents.

Patient/ Guardian Signature: ____________ Date: ____________

Technologists Signature: ____________ Date: ____________