

**PREMIER MEDICAL IMAGING  
Magnetic Resonance Imaging (MRI)**

Date: \_\_\_\_\_ Name: \_\_\_\_\_ Weight: \_\_\_\_\_

**INSTRUCTIONS TO PATIENT:** Please complete the following questions to the best of your knowledge. The technologist and physician performing the examination will use this information.

1. Have you had any recent diagnostic exams that are related to your visit today?  
(please check all that apply)  CT  MRI  X-Ray  PET  Nuclear Medicine  Ultrasound  Mammogram  DEXA  
Where were the procedures performed? \_\_\_\_\_

2. Have you ever worked in a machine shop or similar environment where you have been subjected to small metal shavings? Yes No (please circle)

3. Have you ever had metal in your eyes? Yes No (please circle)

4. Are there any metallic foreign objects in your body? Yes No (please circle)

(please check all that apply)

- |  |  |                                       |  |   |
|--|--|---------------------------------------|--|---|
| <input type="checkbox"/> Harrington Rod          | <input type="checkbox"/> Brain/Aneurysm Clip | <input type="checkbox"/> IUD          | <input type="checkbox"/> Surgical Clips  | <input type="checkbox"/> Pins           |
| <input type="checkbox"/> Joint Replacements      | <input type="checkbox"/> Ocular Implants     | <input type="checkbox"/> Screws       | <input type="checkbox"/> Staples         | <input type="checkbox"/> Ports          |
| <input type="checkbox"/> Breast Implant/Expander | <input type="checkbox"/> Pumps               | <input type="checkbox"/> Shunts       | <input type="checkbox"/> Dental Implants | <input type="checkbox"/> Penile Implant |
| <input type="checkbox"/> Biopsy Marker           | <input type="checkbox"/> Insulin Pump        | <input type="checkbox"/> Filters      | <input type="checkbox"/> Defibulator     | <input type="checkbox"/> Stents         |
| <input type="checkbox"/> Cochlear Implants       | <input type="checkbox"/> Catheters           | <input type="checkbox"/> Other: _____ |  |   |

5. The following items can be hazardous during an MRI exam. Please check if you have any of the following items:  
 Cardiac Pacemaker  Neurostimulators  Heart Valve

6. **FEMALE PATIENTS** Is there a possibility of pregnancy at this time? Yes No (please circle)  
Are you currently breast-feeding? Yes No (please circle)

7. Have you had surgery in your lifetime? Yes No (please circle)

What Kind?	When?	Reason?

8. Have you ever had any cancer in your lifetime? Yes No (please circle)

What Kind?	When?	Reason?

9. Have you had Radiation or Chemotherapy? Yes No (please circle)

What Kind?	When?	Reason?

10. You must remove all jewelry (except wedding ring), metal items, hearing aid(s), and clothing prior to your examination.

**I attest that the answers that I have provided to questions on this form are correct to the best of my knowledge. I have read and understand the entire contents of this form and have had the opportunity to ask questions regarding the information on this form.**

\_\_\_\_\_  
**Signature (patient or guardian)**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Witness**

What is your chief complaint for visiting us today? \_\_\_\_\_  
\_\_\_\_\_

What does your doctor think is causing the problem? \_\_\_\_\_

Was this the result of an accident or injury? Yes No (please circle)  
If **yes**, please describe what happened: \_\_\_\_\_  
\_\_\_\_\_

Please check all the symptoms that you are experiencing, or have experienced with your complaint and shade in those areas on diagram 1 below.

- |                                       |  |  |                                    |
|---------------------------------------|--|--|------------------------------------|
| <input type="checkbox"/> Headache     | <input type="checkbox"/> Confusion           | <input type="checkbox"/> Vision problems | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Black outs   | <input type="checkbox"/> Difficulty walking  | <input type="checkbox"/> Numbness        | <input type="checkbox"/> Weakness  |
| <input type="checkbox"/> Paralysis    | <input type="checkbox"/> Difficulty speaking | <input type="checkbox"/> Seizures        | <input type="checkbox"/> Tremors   |
| <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Depression          | <input type="checkbox"/> Burning         | <input type="checkbox"/> Pain      |

How long have you been experiencing this/these symptoms? \_\_\_\_\_

Does anything you do make it better/worse? \_\_\_\_\_

Do you or your doctor feel a mass? Yes No (please circle)  
If **yes**, please note the mass on the diagram 1 below.

What athletic activities do you participate in? (running, weightlifting, swimming, basketball, football, skiing, etc.) \_\_\_\_\_

Are you currently taking any medications? Yes No (please circle)  
If **yes**, please list them: \_\_\_\_\_

Do you have any other major medical problems (for example: anemia, organ transplants, sickle cell anemia)? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

<p><b>For office use only</b></p> <p>Hx: _____ _____ _____ _____ _____ _____</p> <p>Contrast Information:</p> <p>Contrast/Amount: _____ Location: _____ Complications: _____</p>
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<p><b>For patient use: Diagram 1</b></p>
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