



TO OUR PATIENTS AND ACCOMPANYING FAMILY MEMBERS...

The MR room contains a very strong magnet. Before you are allowed to enter, we must know if you have any metal in your body. Some metal objects can interfere with your scan or may even be dangerous, so PLEASE answer the following questions carefully. If you have a question regarding anything on this form, PLEASE DO NOT HESITATE TO ASK!

Name: _____ DOB: ___/___/___ Height: _____ Weight: _____

- Have you ever had surgery of any kind? If yes, please list them all with dates:
Have you ever been diagnosed with cancer? If yes, please describe:
Are you claustrophobic?
Are you pregnant, possibly pregnant, or breast feeding?
Have you ever had a metal injury to your eye? If yes, was it removed from your eye?
Have you had an MRI since the injury? Where:

Do you have any of these items in your body?

- Cardiac pacemaker, pacer wires, or defibrillator
Brain aneurysm clip
Artificial heart valve
Ear implant (cochlear) or Hearing Aides
Eye implant or eyelid spring
Electrical stimulator for nerves or bone (TENS)
Vagal nerve stimulator
Infusion pump or medication patch
Magnetic or electronic implant
Coil, filter, or stent
Any type of prosthesis (eye, ear, limb, penile)
Shunt
Bullets, BBs, pellets or metal shrapnel
Vascular port or any implanted tube or catheter
Removable dental work, dentures, braces, retainers, or implants
Diaphragm or intrauterine device (IUD)
Surgical clips, staples, wire, mesh or stitches
Orthopedic plates, screws, pins, rods, or wires
Tattoo or body piercings
Location(s)

Information Concerning Gadolinium Contrast

- Have you ever had a previous allergic reaction to gadolinium, MRI contrast dye material?
Do you have any other allergies to food, medicine, etc? If yes, please explain:
Do you have a history of asthma or emphysema?

Questions regarding the procedure

Why did the doctor order the MRI? _____

How long has this been going on? _____

Any recent, accidents, injuries, or surgeries?

If yes, please explain _____

Have you had any other tests of the same area?

X-Ray US MRI CT

Where/When? _____

Does the patient have a current, or past history of any health problems? _____

For MDI use only: _____

Signature (Parent or Guardian)

Date

MDI Interviewer Signature

Date