

MRI - Patient Information

Date: _____

Date of Birth: _____

Name: _____ Weight(lbs): _____

Have you ever worked in a machine shop or similar environment where you have been subjected to small metal slivers, particularly in the eyes? (Please circle) YES NO

Previous MR study? (Please circle) YES NO

Date of type of MRI study: _____

Have you ever had surgery other than dental surgery? (Please circle) YES NO

Date and Type of surgery:

Head and Neck _____

Chest and Abdomen _____

Extremities _____

The following items can interfere with MR imaging and some can actually be hazardous to your safety. Please check if you had any of these items:

- | | |
|---|---------------------------|
| Yes___ No___ Cardiac pacemaker or pacemaker lead wires | |
| Yes___ No___ Brain aneurysm clips | Yes___ No___ Dentures |
| Yes___ No___ Artificial heart valve | Yes___ No___ Aortic clips |
| Yes___ No___ Implanted neurostimulators or lead wires | |
| Yes___ No___ Insulin pump | Yes___ No___ Electrodes |
| Yes___ No___ Hearing aids or cochlear implants | Yes___ No___ IUD |
| Yes___ No___ Joint replacements | Yes___ No___ Shunts |
| Yes___ No___ Metal rods, pins, screws, metal mesh or wire sutures | |
| Yes___ No___ Shrapnel | Yes___ No___ Tattoo |
| Yes___ No___ Others _____ | |

Do not enter the scan room with any metal or magnetic sensitive items.

Check items below if you have any of the following:

- | | | |
|------------------------------|----------------------------|---------------------|
| ___ Jewelry | ___ Removable dental works | ___ Hearing aid |
| ___ Pens | ___ Wallet or money clip | ___ Watch / Glasses |
| ___ Safety pins or hair pins | | ___ Keys or coins |
| ___ Magnetic strip cards | | ___ Pocket knife |

Type of MRI examination you are having today: _____

Any injury to the area? YES ___ NO ___ If yes, date of injury _____

Explain the reason for the MRI: _____

Any particular disease you or your physician would like to rule out? _____