



DATE: _____

NAME: _____

Please Print

HISTORY #: _____

DATE OF BIRTH: _____ / AGE: _____

Have you ever had an MRI study at HSS?

Yes / No

Have you ever had any x-rays at HSS?

Yes / No

How much do you weigh? _____ lbs.

ATTENTION MR 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 and even be dangerous, so please answer the following questions carefully. This is particularly important with regards to prior surgery on the part of the body which we will be scanning.

Have you ever had an operation or surgical procedure of any kind? Please list all surgical procedures including dates:

Yes / No

What does your doctor think is wrong? _____

PACEMAKER, wires or defibrillator

Yes / No

Brain/aneurysm clip

Yes / No

Ear implant or HEARING AID (must be removed prior to MRI)

Yes / No

Infusion pump, or medication pump of any kind

Yes / No

Do you have kidney disease?

Yes / No

If yes, what is your creatinine level: _____ Date: _____

Have you ever been a machinist, welder or metal worker?

Yes / No

Have you ever been hit in the face or eye with a piece of metal (including shavings, slivers, bullets or BBs)?

Yes / No

Have you ever had a piece of metal removed from your eye?

Yes / No

Please Indicate If You Have Any Of The Following Items In Your Body:

- Are you pregnant or breastfeeding? Yes / No
- Do you have claustrophobia (fear of enclosed spaces)? Yes / No
- Eye implant Yes / No
- Electrical stimulator for nerves or bone Yes / No
- Bullets, BBs or pellets Yes / No
- Metal shrapnel or fragments Yes / No
- Magnetic implant (anywhere in the body) Yes / No
- Skin patch for medication Yes / No
- Coil, filter, or wire in a blood vessel Yes / No
- Artificial limb or joint Yes / No
- Eyelid tattoo Yes / No
- Implanted catheter or tube Yes / No
- Artificial heart valve Yes / No
- Penile prosthesis Yes / No
- Shunt Yes / No
- False teeth, retainers, or magnetic braces Yes / No
- Surgical clips, staples, wires, mesh, or sutures Yes / No
- Intrauterine device (IUD) Yes / No
- Orthopaedic hardware (plates, screws, pins, rods, wires) Yes / No
- No
- Tissue expander for future implants. Yes / No

The normal function of the MR unit generates electrical currents which may create a sensation of warmth, either in the sides of the imaging unit or in the surrounding coil. If you experience any focal warmth that leads to discomfort, please notify the technologist immediately.

I attest that the answers 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.

Patient's Signature (or Guardian): _____

Date: _____

Review #1: _____

Reviewer # 2: _____