Name (Please Print):____

*The MRI room contains a very strong magnet. Before you are allowed to enter the room we must know if you have any metal in your body. Some metal objects can interfere with your scan or even be dangerous, so please answer the following questions carefully.

Do you have any of the following?

_____Yes	_____No	***Cardiac pacemaker, pacemaker leads or defibrillator***
_____Yes	_____No	***Brain aneurysm clip***
_____Yes	_____No	***Cochlear ear implant***
_____Yes	_____No	***Metal in eyes or previous injury to eyes involving metal***
_____Yes	_____No	***History of kidney disease/injury or dialysis***
_____Yes	_____No	***Diabetes***
_____Yes	_____No	***Cerebral shunt***
_____Yes	_____No	***Eye or ear implants***
_____Yes	_____No	***Metal shrapnel, bullets, BB's, or pellets***
_____Yes	_____No	***Implanted infusion pump or any mechanical or electrical implants***
_____Yes	_____No	***Coil, filter or wire in blood vessel***
_____Yes	_____No	***Orthopedic hardware (plates, screws, pins, rods, artificial limb or joint)***
_____Yes	_____No	***Implanted catheter or tube (Port-a-cath, Swan-Ganz)***
_____Yes	_____No	***Surgical clips, staples, wires, mesh or sutures***
_____Yes	_____No	***Nitro-patch or other skin patches***
_____Yes	_____No	***Piercing, tattoo or permanent makeup***
_____Yes	_____No	***Dentures or hearing aid***
_____Yes	_____No	***Have you had any previous surgeries? If yes, please state what type and when:*** ______________________
_____Yes	_____No	***Have you (past/present) been diagnosed as having cancer?*** ***If yes, please state what type and where:*** ______________________
_____Yes	_____No	***Have you had chemotherapy or radiation therapy?*** ______________________
_____Yes	_____No	***Do you have hypertension (high blood pressure)?***
_____Yes	_____No	***Have you ever had an allergic reaction to MRI, CT or X-ray Contrast Agent?***

For female patients:
Date of last menstrual period: _____/_____/_____ Post-menopausal? __No __Yes
Are you pregnant or experiencing a late menstrual period? __No __Yes
Are you taking oral contraceptives or receiving hormonal treatment? ___ No ___ Yes
Are you taking any type of fertility medication or having fertility treatments? __ No __ Yes
If yes, please describe: ____
Are you currently breastfeeding? __No __Yes
Intrauterine device (IUD) present? __No __Yes

Your Physician or Providers Name: ____

Name (Please Print):____

Reason for this MRI and/or Symptoms: (Please X all that pertain to this visit)

	Headaches		***Arm Pain ___right ___left***
	Vision loss, changes		***Leg Pain ___right ___ left***
	Dizziness		***Numbness in arms or legs***
	Hearing loss (right, left)		***Neck Pain***
	Ringing in ears		***Upper back Pain***
	Change in bowel function		***Lower back Pain***
	Change in bladder function		***Hip Pain ___right ___left***
	Chest Pain		***Pelvic Pain***

Do you have a lump or mass? ___Yes ___No Location? ___________________________________
Do you have any swelling? ___Yes ___No Location? _____________________________________
How long have you had these symptoms? ____
Is this the result of an injury? ____Yes ____No If yes, describe______________________________
____

Other imaging studies of the area to be scanned (x-rays, CT, MRI, Ultrasound, Nuclear Medicine)?
____
Where? ____
Present medications: ____
____

As part of your exam, the MRI Radiologist may find it advisable to give you an intravenous injection of a contrast agent (MRI dye). This injection may help the physician more accurately diagnose your condition. Although MRI contrast agents have been used safely in millions of cases, minor reactions (principally headache or nausea) occur in about 2% of patients; whereas serious or life threatening reactions have been reported in about one in 400,000 patients.

All questions about the MRI exam are welcomed and no questions are considered unimportant. The MRI exam will be supervised and interpreted by a Board Certified Radiologist associated with Radiology Consultants of Mid-America,PC.

The MRI exam procedure has been explained to me fully. I acknowledge that medicine is not an exact science and I understand that the examination involves some element of risk despite precautions, and that there is a possibility of complications, either directly or indirectly, which may result. Possible common risks as well as the benefits associated with the MRI exam have been explained to me.

I ATTEST THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE. I HAVE READ AND UNDERSTAND THE CONTENTS OF THIS FORM, AND HAD THE OPPORTUNITY TO ASK QUESTIONS REGARDING THE INFORMATION ON THIS FORM, AND REGARDING THE MRI PROCEDURE THAT I AM ABOUT TO UNDERGO.

X Signature (patient or guardian):____

MRI Technologist: _____________________________________Date:________________________