

Fleming County Hospital

MRI Patient History Form

____/____/____
Date

Patient Name

Patient Weight

Patient Age

Is patient a minor? Yes No If yes, _____
Parent/Guardian Signature

Describe symptoms and/or injury: _____

Allergies, please list if any: _____

Does the patient have any of the following: (Please check Yes or No)

- | | |
|--|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Surgery, any type on the head | <input type="checkbox"/> Yes <input type="checkbox"/> No Eye or Orbital Implants |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Denture or Partial Plates | <input type="checkbox"/> Yes <input type="checkbox"/> No Hearing Aides or Devices |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Valve Replacement | <input type="checkbox"/> Yes <input type="checkbox"/> No Neuostimulator or TENS Unit |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Internal Electrodes | <input type="checkbox"/> Yes <input type="checkbox"/> No Diaphragm or IUD |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Implanted Insulin Pump | <input type="checkbox"/> Yes <input type="checkbox"/> No Shunts (Brain or Spine) |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Wire Sutures or Staples | <input type="checkbox"/> Yes <input type="checkbox"/> No Implanted Cardiac Difibulator |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Brain Aneurysm Clips | <input type="checkbox"/> Yes <input type="checkbox"/> No Injury to Eye (Involving Metal or Metallic Shavings) |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Pulse Oximeter | <input type="checkbox"/> Yes <input type="checkbox"/> No Tattooed Eyeliner |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Ear or Cochlear Implants | <input type="checkbox"/> Yes <input type="checkbox"/> No Pacemaker |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No Biostimulator |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Penile Prosthesis | <input type="checkbox"/> Yes <input type="checkbox"/> No Implanted Pain Pump |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Bullets or Shrapnel | <input type="checkbox"/> Yes <input type="checkbox"/> No Metal Mesh Implants |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Previous Back Surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No Orthopedic Pins or Screws |
| <input type="checkbox"/> Yes <input type="checkbox"/> No IV Pump | <input type="checkbox"/> Yes <input type="checkbox"/> No Cardiac Monitor |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Renal Failure | |

Please list ALL previous operations or surgical procedures that the patient has had and the approximate dates:

PREGNANCY

If you are pregnant, approval must be obtained from your Physician and the Radiologist prior to the MRI Exam.

MRI CONTRAST AND REACTIONS

The Radiologist and/or your Physician may deem it necessary to give you an IV injection of a contrast liquid containing Gadolinium to improve the quality of your MRI Examination. Although Gadolinium contrast agents have been used safely in millions of patients, minor reactions (principally headache or nausea) occur in 2% of patients, and serious or life-threatening reactions have been reported in 1 in 400,000 patients.

Patients with moderate to severe cases of renal failure need to be addressed to the Technologist because of recent cases of NSF/NFD. Patients who believe that they may have NSF/NFD should contact their doctor. NSF/NFD is characterized by areas of tight, rigid skin and scarring of body organs. Signs of NSF/NFD also include: burning; itching; swelling; hardening and tightening of the skin; red or dark patches on the skin; yellow spots on the whites of the eyes; stiffness in joints with trouble moving or straightening the arms, hands, legs or feet; pain in the hip bones or ribs; and muscle weakness.

METAL DEVICES

I have informed the Technologist that I have no metallic devices such as a pacemaker; implant; and/or cerebral aneurysm clips in my body or any metallic foreign bodies in my eyes.

I understand the effects of the contrast and agree to have it done. I have answered these questions to the best of my knowledge and understand the information presented to me.

Patient/Guardian Signature

_____/_____/_____
Date

Contraindications and/or X-Rays Reviewed By

_____/_____/_____
Date