MRI Scan History Form

FOR OFFICE USE ONLY	
IV Contrast:	_____ cc
iSTAT / Lab	_____ Creatinine _____Date
IV gauge:	_____ / Site _____ / Initials_____

Name: _____

Date: _____ Weight: _____

Sex: ☐ Male ☐ Female Age: _____ Exam Type(s) _____

1. Please describe your current symptoms: _____

   _____

2. How long have you had the above symptoms: _____

3. Have you ever had any type of surgery? ☐ Yes ☐ No

   If yes, please list types and dates performed: _____

   _____

4. Have you ever had any type of cancer? ☐ Yes ☐ No

   If yes, please list types and dates diagnosed: _____

   _____

5. Have you had radiation and/or Chemo Therapy to treat cancer? ☐ Yes ☐ No

   If yes, please indicate which type (radiation, Chemo Therapy [or both]) and dates performed: _____

6. Have you had any vascular surgery or vascular stents placed? ☐ Yes ☐ No

   If yes, please list types and dates performed: _____

   _____

7. Have you had any previous CAT Scan, MRI Scan or Ultrasounds related to the test you are having today? ☐ Yes ☐ No If yes where / when were they done: _____

   _____

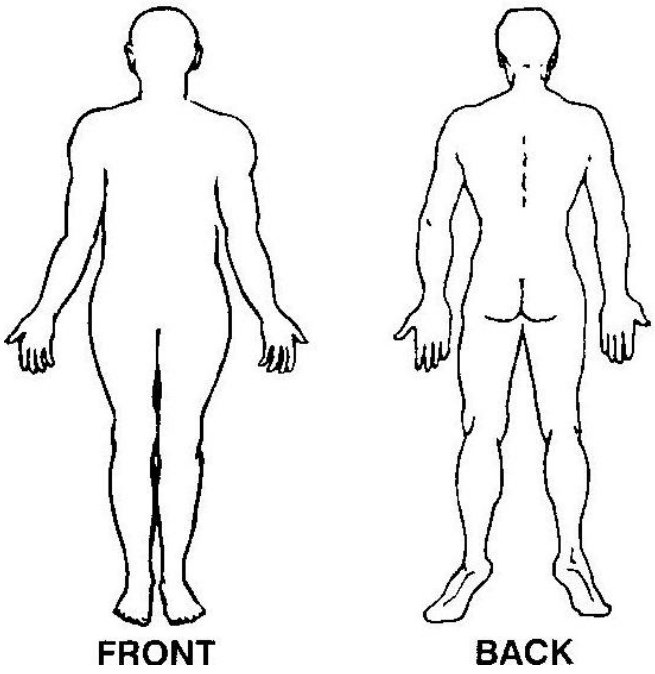
8. Are you a diabetic? ☐ Yes ☐ No If yes, how long? _____

9. Do you have any kidney problems that you are aware of? ☐ Yes ☐ No

10. Do you have 2 kidneys? ☐ Yes ☐ No

Continued on reverse side

Please indicate where you are having pain / symptoms



MRI Checklist

Do You Have?	YES	NO
Pacemaker		
Brain Aneurysm Clip		
Claustrophobia		
Ear Implant		
Internal Pump		
Neurostimulator		
Cardiac Defibrillator		
Pregnant or breastfeeding.		
Shrapnel Injury		
Stent [less than 8 weeks]		
Removable Dentures / Bridge		
Hearing Aid		
Tattoo / Permanent Makeup		
Breast Tissue Expanders		
Any other metal or mechanical devices in your body?		

Patient Signature: _____