

**UHC RADIOLOGY
MRI PATIENT HISTORY**

Patient Name: _____

SEX: M F

Date: _____

Patient ID#: _____

DATE OF BIRTH _____

BEFORE HAVING YOUR MRI SCAN, IT IS IMPORTANT FOR US TO KNOW IF YOU HAVE ANY OF THE FOLLOWING:
(Please circle the correct response)

- | | | |
|--------------------------------------------------------------------------------------------------------------|-----|----|
| 1. Have You Ear Surgery For Cochlea Implant? | YES | NO |
| 2. Do You Have Aneurysm Clips In Your Head From Previous Surgery? | YES | NO |
| 3. Do You Have A Pacemaker, Defibrillator or Pacing Wires? | YES | NO |
| 4. Do You Have A Heart Replacement Valve Or Any Stents? | YES | NO |
| If Yes Date Placed: ____ - ____ - ____ Do You have a Card for the Stent? | | |
| 5. Is It Possible That You May Have Metal Filings Or Splinters
In Your Eyes or Any Shrapnel In Your Body? | YES | NO |
| 6. Do You Have An Infusion Pump? (Insulin or medication) | YES | NO |
| 7. Do You Have Permanent Eyeliner, Tattoo's, Body Piercing, Wig, Or Hairpiece? | YES | NO |
| 8. Do You Have A Nerve or Bone Stimulator (T.E.N.S. unit) or Any Implant? | YES | NO |
| List Implants: _____ | | |
| 9. Are You Pregnant Or Breastfeeding? | YES | NO |
| 10. Are You Wearing A Medication Patch or Have ECG, EKG, EEG leads? | YES | NO |
| 11. Do You Have A Breast Tissue Expander? | YES | NO |
| If So, Name of Physician Who Implanted It: _____ | | |
| 12. Do You Have Any Allergies (To Any Food Or Medication) | YES | NO |
| If Yes, Please List: _____ | | |
| 13. Are You On Dialysis Or A History Of Kidney Failure Or End stage Renal Disease? | YES | NO |
| 14. Do you have chronic liver disease, have you had or are you expecting a recent liver transplant? | YES | NO |
| 15. Have You Had Any Other Tests For Your Current Problem? | YES | NO |
| If Yes, Where And When: _____ | | |

Medication History: (For Out-Patients Only – For In-Patients see PCOSS)

Please provide information about each **prescription medication, herbal supplement, or over the counter (OTC) medication** that you are currently taking.

DRUG NAME	DOSE (strength/quantity)	ROUTE (oral, IV, etc.)	HOW OFTEN	LAST DOSE (date and time)

The information I have provided is correct to my knowledge

Patient Signature: _____

Date: _____