

NAME: \_\_\_\_\_ D.O.B: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

(Last) (First)

AGE: \_\_\_\_\_ SEX: M / F WEIGHT: \_\_\_\_\_ HEIGHT: \_\_\_\_ ft. \_\_\_\_ in.

REFERRING PHYSICIAN: \_\_\_\_\_

- What type of problem are you having? \_\_\_\_\_
- Was this a result of an injury? \_\_\_\_\_
- How long have you had this problem? \_\_\_\_\_
- Do you have a history of being diagnosed with cancer? Yes \_\_\_\_ No \_\_\_\_ Type \_\_\_\_\_
- Have you been treated with either radiation or chemotherapy? (If yes, circle) Date completed \_\_\_\_\_
- Have you had brain surgery? Yes \_\_\_\_ No \_\_\_\_ If yes, when \_\_\_\_\_

**Do you have, or have you ever had, any of the following? (If yes, circle)**

- |                                                                  |                                            |                       |
|------------------------------------------------------------------|--------------------------------------------|-----------------------|
| <b>PACEMAKER/DEFIBRILLATOR</b>                                   | <b>METAL SLIVERS IN EYES</b>               | <b>IUD</b>            |
| <b>DIABETES or KIDNEY DISEASE</b>                                | <b>SHRAPNEL (bomb or bullet fragments)</b> | <b>HEARING AID</b>    |
| <b>COCHLEAR IMPLANTS</b>                                         | <b>BREAST TISSUE EXPANDER</b>              | <b>BODY PIERCING</b>  |
| <b>HEART VALVE REPLACEMENT</b>                                   | <b>NEURO STIMULATOR</b>                    | <b>PENILE IMPLANT</b> |
| <b>TATOOS (over 20 years old)</b>                                | <b>PESSARY (bladder support)</b>           | <b>ANEURYSM CLIPS</b> |
| <b>REMOVABLE DENTAL WORK/DENTURES</b>                            |                                            |                       |
| <b>ENDOSCOPY CLIPS/INGESTED PILL CAMERA/PH BRAVO CAPSULE</b>     |                                            |                       |
| <b>MEDICATION PATCH (birth control/nicotine/Nitroglycerine)</b>  |                                            |                       |
| <b>ANY EXTERNAL/INTERNAL PUMPS (i.e., Insulin, chemotherapy)</b> |                                            |                       |

**Have you had any imaging studies of your head or neck? Yes \_\_\_\_ No \_\_\_\_**

Type of study \_\_\_\_\_ Where \_\_\_\_\_ When \_\_\_\_\_

**DO YOU HAVE ANY HISTORY OF:**

- |                      |          |         |                    |          |         |
|----------------------|----------|---------|--------------------|----------|---------|
| Brain Aneurysm       | Yes ____ | No ____ | Loss of Hearing    | R ____   | L ____  |
| Stroke               | Yes ____ | No ____ | Arm Weakness       | R ____   | L ____  |
| Seizures             | Yes ____ | No ____ | Leg Weakness       | R ____   | L ____  |
| Trauma               | Yes ____ | No ____ | Loss of Balance    | Yes ____ | No ____ |
| Dizziness            | Yes ____ | No ____ | Memory Loss        | Yes ____ | No ____ |
| Cerebral Arteriogram | Yes ____ | No ____ | Facial Pain        | Yes ____ | No ____ |
| Blurred Vision       | Yes ____ | No ____ | Sinus Trouble      | Yes ____ | No ____ |
| High Blood Pressure  | Yes ____ | No ____ | Headaches or Fever | Yes ____ | No ____ |

1. If Yes, briefly describe \_\_\_\_\_

- Do you have a history of allergies? Yes \_\_\_\_ No \_\_\_\_ If so, what kind? \_\_\_\_\_
- **Are you pregnant, or is there a possibility that you might be pregnant? Yes \_\_\_\_ No \_\_\_\_**

I acknowledge that all the information given is accurate and thereby consent to have Magnetic Resonance Imaging with or without an injection of contrast performed on me. I do not have a pacemaker. I have removed all hearing aids and dentures and any external pumps and monitoring devices..

\_\_\_\_\_  
Signature of Patient or Legal Guardian

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Technologist's Initials: \_\_\_\_\_

**Technologist to Complete the Section Below**

MR # \_\_\_\_\_ Designated Physician On-Site: \_\_\_\_\_

Tech: \_\_\_\_\_ Supervising Physician (if different): \_\_\_\_\_

Contrast Used: **OPTIMARK** / \_\_\_\_\_ mls Lot # \_\_\_\_\_