Summit Diagnostic Imaging

MRI/CT MEDICAL HISTORY

(Please Print)

Date _____/_____/_____

Name _____ D.O.B. _____ Weight _____ lbs.

What symptoms or complaints brought you here today? _____

Are you taking any medications? (Including NSAID's Antibiotics, Meds for Arthritis) ☐ Yes ☐ No

List current medications: _____

Are you allergic to any foods or medications? ☐ Yes ☐ No

If yes, please list _____

Have you ever had x-ray contrast dye? (Kidney dye or CT dye) ☐ Yes ☐ No Reaction? ☐ Yes ☐ No

What kind of reaction? _____

Have you ever had MRI contrast dye? ☐ Yes ☐ No Reaction? ☐ Yes ☐ No

What kind of reaction? _____

MEDICAL HISTORY:

Check if you have any of the following:

- ☐ Lung Problems
- ☐ High Blood Pressure
- ☐ Liver Disease
- ☐ Other Medical Problems
- ☐ Asthma
- ☐ Diabetes
- ☐ Weight Loss
- ☐ Kidney Problems
- ☐ Sickle Cell Disease
- ☐ Previous Head Injury
- ☐ Multiple Myeloma
- ☐ Heart/Cardiac Problems / Explain: _____
- ☐ Seizures
- ☐ Smoking History _____years smoked _____ ppd _____ quit year
- ☐ Cancer ? (List types) _____

  Chemotherapy ☐ Yes ☐ No Date last chemo _____/_____/_____

  Radiation Therapy ☐ Yes ☐ No Date last radiation _____/_____/_____
- ☐ None of the above

PREVIOUS SURGERY:

Type: _____ Date:_____/_____/_____

Type: _____ Date:_____/_____/_____

Type: _____ Date:_____/_____/_____

FOR FEMALE PATIENTS:

Please give the approximate date of your last menstrual period _____/_____/_____

Is there a possibility you could be pregnant ? ☐ Yes ☐ No

Are you currently nursing a child or breast feeding ? ☐ Yes ☐ No

OFFICE USE ONLY:

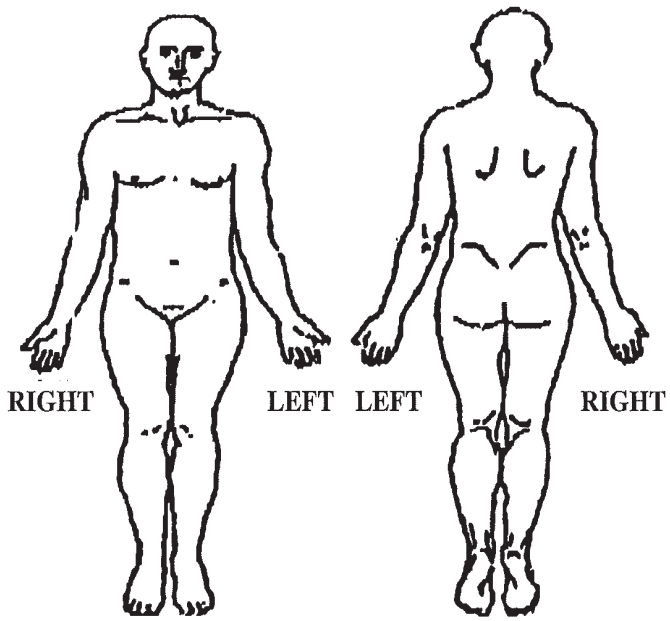
Contrast and Amount _____ Time of inject _____ Tech. Signature _____

WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure (i.e., MRI, MR angiography, functional MRI, MR spectroscopy). Do not enter the MR system room of MR environment if you have any question or concern regarding an implant, device, or object. Consult the MRI Technologist or Radiologist BEFORE entering the MR system room. The MR system magnet is ALWAYS on.

Please indicate if you have any of the following:

☐ Yes ☐ No	Aneurysm clip(s)
☐ Yes ☐ No	Cardiac pacemaker
☐ Yes ☐ No	Implanted cardioverter defibrillator (ICD)
☐ Yes ☐ No	Electronic implant or device
☐ Yes ☐ No	Magnetically-activated implant or device
☐ Yes ☐ No	Neurostimulation system
☐ Yes ☐ No	Spinal cord stimulator
☐ Yes ☐ No	Internal electrodes or wires
☐ Yes ☐ No	Bone growth/bone fusion stimulator
☐ Yes ☐ No	Cochlear, otologic, or other ear implant
☐ Yes ☐ No	Insulin or other infusion pump
☐ Yes ☐ No	Implanted drug infusion device
☐ Yes ☐ No	Any type of prostheses (eye
☐ Yes ☐ No	Heart valve prosthesis
☐ Yes ☐ No	Eyelid spring or wire
☐ Yes ☐ No	Artificial or prosthetic limb
☐ Yes ☐ No	Metallic stent, filter, or coil
☐ Yes ☐ No	Shunt (spinal or intraventricular)
☐ Yes ☐ No	Vascular access port and/or catheter
☐ Yes ☐ No	Radiation seeds or implants
☐ Yes ☐ No	Swan-Ganz or thermodilution catheter
☐ Yes ☐ No	Medication patch (Nicotine, Nitroglycerine)
☐ Yes ☐ No	Any metallic fragment or foreign body
☐ Yes ☐ No	Wire mesh implant
☐ Yes ☐ No	Tissue expander (e.g. breast)
☐ Yes ☐ No	Surgical staples, clips, or metallic sutures
☐ Yes ☐ No	Joint replacement (hip, knee, etc.)
☐ Yes ☐ No	Bone, joint pin, screw, nail, wire plate, etc.
☐ Yes ☐ No	IUD, diaphragm, or pessary
☐ Yes ☐ No	Dentures or partial plates
☐ Yes ☐ No	Tattoo or permanent makeup
☐ Yes ☐ No	Body piercing jewelry
☐ Yes ☐ No	Hearing aid *(Remove before entering MR system room)*
☐ Yes ☐ No	Other implant _____
☐ Yes ☐ No	Breathing problem or motion disorder
☐ Yes ☐ No	Claustrophobia
❑ Yes ❑ No	Do you wear contact lenses?

Please mark on the figure(s) below the location of any implant or metal inside of or on your body.



IMPORTANT INSTRUCTIONS

Before entering the MR environment or MR system room, you must remove all metallic objects including hearing aids, dentures, partial plates, keys, beeper, cell phone, eyeglasses, hair pins, barrettes, jewelry, body piercing jewelry, watch, safety pins, paper clips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools, clothing with metal fasteners, & clothing with metallic threads.

Please consult the MRI Technologist or Radiologist if you have any question or concern BEFORE you enter the MR system room.

NOTE: You may be advised or required to wear earplugs or other hearing protection during the MR procedure to prevent possible problems or hazards related to acoustic noise.

I attest that the above information is correct to the best of my knowledge. I read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and regarding the MR procedure that I am about to undergo.

Signature of Person Completing Form: _____ Date _____/_____/_____
Signature

Form Completed By: ❑ Patient ❑ Relative ❑ Nurse

Print Name _____ Relationship to Patient _____

Form Information Reviewed By: _____ _____
Print Name *Signature*

❑ MRI Technologist ❑ Nurse ❑ Radiologist ❑ Other _____