Houston MRI & Diagnostic Imaging

Facility:	Referring:
MRN:	Radiologist:
DOS:	Delivery:

MRI PATIENT HISTORY FORM

Patient Name: _____ Date: _____
Date of Birth: _____ Height: _____ Weight: _____

Type of Exam: _____

When is your next follow-up appointment with your doctor? _____

Describe your symptoms for today's visit: _____

_____

Were you injured? ○Yes ○No If yes, when? _____ How (enter details)? _____

_____

Have you had any surgery relating to this area? ○Yes ○No If yes, when? _____

Have you had other surgeries? ○Yes ○No If yes, what type and when? _____

_____

Have you had any previous imaging studies related to today's procedure? ○Yes ○No

If yes, please list type of study, date, and location: _____

Are you currently taking or have you recently taken any medications? ○Yes ○No

If yes, please list: _____

Do you have any allergies? ○Yes ○No Are you allergic to contrast used for MRI's? ○Yes ○No

If yes, please list: _____

Do you have or have you had any of the following:

AIDS or HIV	○Yes ○No	Diabetes	○Yes ○No	Liver Disease	○Yes ○No
Anemia	○Yes ○No	Dialysis	○Yes ○No	Mononucleosis	○Yes ○No
Asthma	○Yes ○No	Hepatitis	○Yes ○No	Sickle Cell Anemia	○Yes ○No
Cardiac problems	○Yes ○No	Hypoglycemia	○Yes ○No	Stroke	○Yes ○No
Grand Mal Seizures	○Yes ○No	Kidney Disease	○Yes ○No	Ulcers	○Yes ○No
Cancer	○Yes ○No	Type: _____			

Please list any other medical conditions not listed above:

_____

FEMALE PATIENTS ONLY

I am pregnant (or may be)	○Yes ○No	Onset of last menstrual period	_____/_____/_____
I use an IUD	○Yes ○No	I have had a hysterectomy	○Yes ○No
I am breastfeeding	○Yes ○No	I am postmenopausal	○Yes ○No

Patient Signature: _____ Date: _____/_____/_____

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MRI SAFETY CHECKLIST AND PATIENT CONSENT FORM

PATIENT NAME _____ **PATIENT ID #** _____

Patients: **Height**: _____ **Weight**: _____

Magnetic Resonance Imaging (MRI) provides your doctor with the latest technology available for imaging soft tissue of the body. MRI utilizes a strong magnetic field and radio frequencies, both of which have, as of yet, not proven to exhibit any long-term effects. Patients with cardiac pacemakers cannot undergo an MRI. Patients who have had surgery to implant other metal devices in the body may be able to safely have an MRI if they do not have ferromagnetic devices placed at critical locations. Patients exposed to metal grinding may have metal in their eyes. An x-ray may be necessary to detect the location of metal objects in the body. Special attention must be given to possible magnetic sensitive devices that may be placed within the body.

Please answer the following questions:

- ☐ Yes ☐ No Are you 60 years, or over? **For contrast studies, if yes, current lab report needed and Rad approval**
- ☐ Yes ☐ No Do you have a pacemaker?
- ☐ Yes ☐ No Do you have metal aneurysm clips?
- ☐ Yes ☐ No Have you ever had metal in your eyes?
- ☐ Yes ☐ No Have you ever been injured by shrapnel, BB, bullets, pellets, or any other pieces of metal that are still present in your body?
  If yes, did a doctor get it all out? _____
- ☐ Yes ☐ No Do you have any pins, screws, wires, metal rods or plates still present in your body?
  If yes, explain what, which one, and location? _____
- ☐ Yes ☐ No Have you ever had head, eye, ear or heart surgery?
  If yes, where, when, and what kind of surgery? _____
- ☐ Yes ☐ No Are you claustrophobic? ***If yes, have referring physician order medication***
- ☐ Yes ☐ No Are you pregnant, or is there a chance that you could be pregnant? (***No IV contrast if pregnant***)
- ☐ Yes ☐ No Are you breast feeding? (***If breast-feeding, IV contrast patient must wait for 24 hours after***)
- ☐ Yes ☐ No Moderate to end stage kidney/liver disease? (***If yes, we cannot administer contrast***)
- ☐ Yes ☐ No History of Hypertension? **For contrast studies, if yes, current lab report needed and Rad approval**
- ☐ Yes ☐ No History of Diabetes? **For contrast studies, if yes, current lab report needed and Rad approval**
- ☐ Yes ☐ No Have you had any X-Rays, Cat Scans, MRI's related to the exam ordered?
  If yes, these films must be brought with you on the day of your exam

Please place a check mark by the following items that apply to you.

- ☐ Aortic, carotid or arterial clips
- ☐ Artificial heart valve
- ☐ Artificial eye or limb
- ☐ Brain surgery
- ☐ Bone pins, screws, or joint replacement
- ☐ Bridge work, dentures or partial plates
- ☐ Carotid clips
- ☐ Cochlear or inner ear implants
- ☐ Ear shunts
- ☐ Electronic monitoring devices
- ☐ Harrington (spinal) rods
- ☐ Arterial or venous catheters
- ☐ Hearing aids
- ☐ Inner ear surgery
- ☐ Insulin or infusion pumps
- ☐ Intrauterine Device (IUD) - contraceptive
- ☐ Neurostimulators
- ☐ Permanent cosmetic eye lining or tattoos
- ☐ Prosthesis (eye, penile, etc.)
- ☐ TENS unit
- ☐ Wire mesh, wire sutures, staples
- ☐ Bone growth stimulators
- ☐ Any implant held in place with a magnet

I have reviewed the above list and have informed the staff of scheduled facility of any possible metal within my body. I understand the risks and hazards associated with inaccurate information. The MRI exam may require an intravenous injection of contrast or medication. The introduction of contrast or drugs into the body, rarely cause mild to severe reaction. Your signature indicates that you understand the above mentioned information and all your questions have been accurately answered and that you are giving our facility consent to perform an MRI exam, including the possible injection of a contrast agent and/or medication as deemed necessary by the radiologist.

Patient Signature: _____ Date: _____
(or legal guardian if minor)

Medical Staff Signature: _____ Date: _____