Date: _____

Reason for Exam: _____

Weight: _____ Height: _____ Injury: ☐ Yes ☐ No Date of Injury: _____

Previous MRI/CT: _____

Do you have a Pacemaker or Defibrillator	☐ Yes	☐ No	Neurostimulator or TENS Unit	☐ Yes	☐ No
Are you Pregnant or Breast feeding	☐ Yes	☐ No	Fractured Bones treated with		
Are you Claustrophobic	☐ Yes	☐ No	pins, rods, screws	☐ Yes	☐ No
Heart Valve or Heart Stent	☐ Yes	☐ No	Prosthesis of any kind	☐ Yes	☐ No
Eye Surgery or Eye Implants	☐ Yes	☐ No	Metallic implant, Shrapnel or Bullets	☐ Yes	☐ No
Hearing Aid	☐ Yes	☐ No	Body piercing (besides ears)	☐ Yes	☐ No
Ever had metal in your eyes	☐ Yes	☐ No	Wig or Hair piece	☐ Yes	☐ No
Brain Surgery	☐ Yes	☐ No	Dentures	☐ Yes	☐ No
Aneurysm Clips/Vascular Clips	☐ Yes	☐ No	Tattoos	☐ Yes	☐ No
Ear Surgery or Ear Implants	☐ Yes	☐ No	Dermal patch	☐ Yes	☐ No
Allergic Reactions (Dye, Latex, Meds)	☐ Yes	☐ No	Have you every had cancer	☐ Yes	☐ No
Insulin or Chemo Pump	☐ Yes	☐ No	Do you have kidney disease	☐ Yes	☐ No

List **ALL** Previous Surgeries to all body parts: _____

_____

List **ALL** Medical Problems: _____

_____

List **ALL** Medications: _____

_____

Patient or Guardian Signature: _____ **Date:** _____ **Time:** _____

FOR TECHNOLOGIST:

Patient complaints: _____

_____

Contrast type: _____ Amount Used: _____

Lot Number: _____ Expiration: _____

Serum Creatinine _____ GFR _____ Date: _____

Was Patient Able to Cooperate? ☐ Yes ☐ No

Technologist Signature: _____ **Date:** _____ **Time:** _____

Additional notes: _____

SOUTHERN SURGICAL HOSPITAL

SSH-RAD022 7/11

MRI PATIENT HISTORY AND INFORMATION

Patient Label