MRI CHEST, ABDOMEN, PELVIS
PATIENT HISTORY AND SCREENING

Name:_____ Referring Physician: _____

Please explain your present complaint or problem in detail_____

_____

How long have you had this problem?_____

Any previous injury or surgery to this area? ❑ Yes ❑ No

If yes, please explain _____

Do you have a history of cancer? ❑ Yes ❑ No

If yes, please explain _____
When was it diagnosed?_____

Have you had any previous studies of the body part being scanned today? ❑ Yes ❑ No

If yes, type of study? _____
Where and when? _____

Do you have a history of renal or liver disease? ❑ Yes ❑ No

Are you on dialysis? ❑ Yes ❑ No

Are you a diabetic? ❑ Yes ❑ No

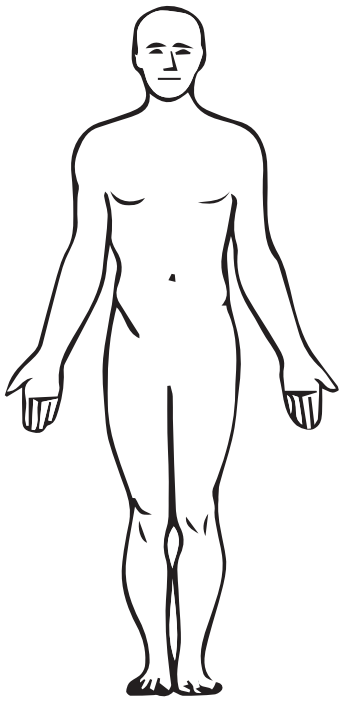
Are you on diabetes meds? ❑ Yes ❑ No

Do you have high blood pressure? ❑ Yes ❑ No

Are you on hypertension meds? ❑ Yes ❑ No

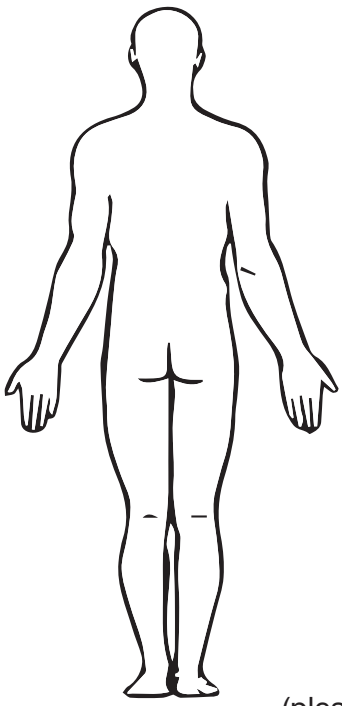
FRONT

Right Side Left Side



BACK

Left Side Right Side



(please turn over)

DIAGNOSTIC RADIOLOGY & IMAGING
we see you.

NAME:_____

DOB:_____

WEIGHT:_____ **lbs.**_____

The following items may be harmful to you during your MRI Scan or may interfere with the MRI examination. You must provide a ''yes'' or ''no'' for every item. Please indicate if you have, or have had any of the following:

*** SIGNATURE:**	**YES**	**NO**
Any type of electronic, mechanical, or magnetic implant: eye, ear (otologic, cochlear, or other ear implant), penile, or other If yes, type: _____	☐	☐
Cardiac pacemaker	☐	☐
Aneurysm clip	☐	☐
Implanted cardiac defibrillator (ICD)	☐	☐
Neurostimulator / biostimulator (e.g., spinal cord or brain stimulator) If yes, type _____	☐	☐
Any type of internal electrodes or wires	☐	☐
Hearing aid	☐	☐
Implanted drug pump (e.g., insulin, baclofen, chemotherapy, pain medicine)	☐	☐
Halo vest	☐	☐
Spinal fixation device	☐	☐
Spinal fusion procedure	☐	☐
Any type of coil, filter, or stent If yes, where and what type? _____	☐	☐
Any type of metal object (e.g., shrapnel, bullet, BB, metal fragment, or foreign body)	☐	☐
Bone growth / bone fusion stimulator	☐	☐
Artificial heart valve	☐	☐
Eyelid spring	☐	☐
Any type of surgical clip or staple	☐	☐
Any IV access port (e.g., Broviac, Port-a-Cath, Hickman, PICC line)	☐	☐
Medication patch (e.g., nitroglycerin, nicotine)	☐	☐
Shunt (spinal or intraventricular)	☐	☐
Prosthesis (artificial limb, joint, or eye) If yes, location:_____	☐	☐
Tissue expander (e.g., breast)	☐	☐
Removable dentures, false teeth or partial plate	☐	☐
Diaphragm, IUD, pessary If yes, type: _____	☐	☐
Surgical mesh If yes, location _____	☐	☐
Body piercing, including dermal (under the skin) If yes, location _____	☐	☐
Permanent makeup (tattoos or tattooed eyeliner)	☐	☐
Radiation seeds (e.g., cancer treatment)	☐	☐
Bone / joint pins, rods, screws, nails, plates, wires, etc. If yes, location:_____	☐	☐
Tracking device (such as an ankle bracelet provided by law enforcement)	☐	☐

TECHNOLOGIST:_____

MRNOTE