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4930 Overland Drive
Lawrence, KS 66049

medimageks.com

Advanced Medical Imaging

Patient Name:_____ Date of Birth:_____ Height_____ Weight_____

MRI SAFETY SCREENING AND MEDICAL HISTORY

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:

☐ YES ☐ NO INJURY TO THE EYES INVOLVING METAL?

☐ YES ☐ NO BRAIN ANEURYSM CLIPS OR BRAIN SURGERY?

☐ YES ☐ NO EYE SURGERY/IMPLANTS/SPRINGS/WIRES/ RETINAL TACKS?

☐ YES ☐ NO EAR SURGERY/COCHLEAR IMPLANTS/HEARING AIDS/STAPES IMPLANTS?

☐ YES ☐ NO DENTURES/PARTIALS/DENTAL IMPLANTS?

☐ YES ☐ NO CARDIAC PACEMAKER/PACER WIRES/ICD

☐ YES ☐ NO HEART SURGERY OR HEART VALVE?

☐ YES ☐ NO SHUNTS/STENTS/FILTERS/INTRAVASCULAR CLIPS?

☐ YES ☐ NO NEUROSTIMULATOR/BIOSTIMULATOR?

☐ YES ☐ NO IMPLANTED DRUG INFUSION PUMP/INSULIN PUMP?

☐ YES ☐ NO ORTHOPEDIC PINS/ SCREWS/ RODS/ JOINT PROSTHESIS?

☐ YES ☐ NO ARE YOU WEARING A SUPPORT BRACE?

☐ YES ☐ NO ENDOSCOPIC/GI PROCEDURE LAST 60DAYS?

☐ YES ☐ NO ELECTRICAL/MECHANICAL/MAGNETIC IMPLANTS?

☐ YES ☐ NO ANY SURGICAL CLIPS NOT LISTED ABOVE?

☐ YES ☐ NO METAL MESH IMPLANTS/WIRE SUTURES/STAPLES CLIPS/INTERNAL ELECTRODES?

☐ YES ☐ NO TATTOOS/PERMANENT MAKE-UP/BODY PIERCING/ MEDICATION PATCHES?

☐ YES ☐ NO PINS IN CLOTHING/HAIR/HAIR PIECES/WIGS?

☐ YES ☐ NO GUNSHOT WOUNDS/SHRAPNEL/ BB'S?

☐ YES ☐ NO HAVE YOU EVER HAD AN MRI BEFORE

IF YES ANY PROBLEMS_____

☐ YES ☐ NO ARE YOU CLAUSTROPHOBIC?

☐ YES ☐ NO ANY CHANCE OF PREGNANCY?

☐ YES ☐ NO ARE YOU CURRENTLY BREAST FEEDING?

CONTRAST QUESTIONNAIRE:

☐ YES ☐ NO ARE YOU BEING TREATED FOR HIGH BLOOD PRESSURE?

☐ YES ☐ NO DO YOU HAVE RENAL(KIDNEY) DISEASE?

☐ YES ☐ NO ARE YOU DIABETIC?

☐ YES ☐ NO DO YOU HAVE LIVER DISEASE?

☐ YES ☐ NO HAVE YOU EVER HAD AN ORGAN TRANSPLANT?

☐ YES ☐ NO HAVE YOU EVER HAD MRI CONTRAST BEFORE?

IF YES ANY PROBLEMS_____

☐ YES ☐ NO ARE YOU CURRENTLY TAKING ANY MEDICATIONS?

IF SO PLEASE LIST _____

_____

_____

☐ YES ☐ NO ANY KNOWN DRUG ALLERGIES?

IF SO PLEASE LIST _____

_____

PLEASE LIST SURGICAL HISTORY?_____

_____

_____

☐ YES ☐ NO PERSONAL HISTORY OF CANCER?

IF YES PLEASE LIST TYPE AND LOCATION

_____

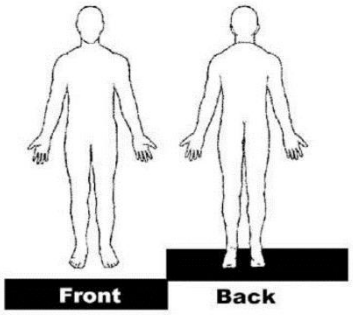
☐ YES ☐ NO CHEMOTHERAPY/RADIATION?

IF YES DATE OF LAST TREATMENT _____

DATE OF INJURY OR WHEN PAIN BEGAN _____

HOW LONG HAVE YOU BEEN HAVING SYMPTOMS?_____

PLEASE MARK THE LOCATION OF YOUR SYMPTOMS



ACKNOWLEDGMENT

I have read and understand the contents of this form. I attest that the information provided on this form is correct to the best of my knowledge I acknowledge depending on the necessity and my renal function, contrast maybe administered. I acknowledge that I am aware of the possible side effects, and I have had the opportunity to ask questions related to this form, the MRI procedure and the contrast.

PATIENT SIGNATURE:_____

DATE: _____

TECHNOLOGIST SIGNATURE_____ CONTRAST NAME_____ DOSE _____

DATE_____ LOT#_____ EXPIRATION ATE_____ ROUTE _____