

NAME: _____ D.O.B: ____/____/____
(Last) (First)

AGE: _____ SEX: M/F WEIGHT: _____ HEIGHT: ____ ft. ____ in. MR# _____

REFERRING PHYSICIAN: _____

- What type of problem are you having? _____
- Was this a result of an injury? _____
- How long have you had this problem? _____
- Do you have a history of being diagnosed with cancer? Yes ___ No ___ Type _____
- Have you been treated with either Radiation or Chemotherapy? (If yes, circle) Date completed _____
- Have you had Brain Surgery? Yes ___ No ___ If yes, when? _____

Do you have, or have you ever had any of the following? (If yes, circle)

- | | |
|--------------------------------|--|
| PACE MAKER | METAL SLIVERS IN EYES |
| ANEURYSM CLIPS | SHRAPNEL (bomb or bullet fragments) |
| COCHLEAR IMPLANTS | HEARING AID |
| HEART VALVE REPLACEMENT | REMOVABLE DENTAL WORK/DENTURES |
| NEURO STIMULATOR | TATTOOS (over 20 yrs old) |
| BODY PIERCING | PENILE IMPLANT |

Have you had any imaging studies of your head or neck? Yes ___ No ___

Type of study _____ Where _____ When _____

DO YOU HAVE ANY HISTORY OF:

- | | | | |
|----------------------|----------------|--------------------|----------------|
| Brain Aneurysm | Yes ___ No ___ | Loss of Hearing | R ___ L ___ |
| Stroke | Yes ___ No ___ | Arm Weakness | R ___ L ___ |
| Seizures | Yes ___ No ___ | Leg Weakness | R ___ L ___ |
| Trauma | Yes ___ No ___ | Loss of Balance | Yes ___ No ___ |
| Dizziness | Yes ___ No ___ | Memory Loss | Yes ___ No ___ |
| Cerebral Arteriogram | Yes ___ No ___ | Facial Pain | Yes ___ No ___ |
| Blurred Vision | Yes ___ No ___ | Sinus Trouble | Yes ___ No ___ |
| High Blood Pressure | Yes ___ No ___ | Headaches or Fever | Yes ___ No ___ |

If Yes, briefly describe _____

- Do you have a history of allergies? Yes ___ No ___ If so, what kind? _____
- Are you pregnant, or is there a possibility that you might be pregnant? Yes ___ No ___

I acknowledge that all the information given is accurate and thereby consent to have Magnetic Resonance Imaging performed on me.

I do not have a pacemaker. I have removed all hearing aids & dentures.

_____ Date: ____/____/____

Patient's Signature

Technologist to Complete Below this Line

Rad authorizing IV Contrast _____ Tech: _____ Study Protocolled by: _____

Contrast Used: _____ / _____ cc's Lot # _____ Study checked by: _____