

Briefly describe your symptoms and indicate how long you have had these symptoms of the area being imaged: _____

Did you have an injury, how? _____

Injury date, if applicable: _____

Was injury related to a fall? Yes No

Have you had previous surgery in the area to be scanned? Yes No

If yes, describe what was done and when, where, Dr.: _____

Has your physician done any injections to the site? _____

Have you had any of the following? If so, indicate when, where:

TEST	WHEN	WHERE	RESULTS
Myelogram			
CT Scan			
MRI Scan			
Ultrasound, Nuclear			

INDICATE SYMPTOMS:

Please Check:	RIGHT	LEFT	BOTH
Arm pain			
Neck pain			
Back pain			
Leg pain			
Tingling or numbness			
Weakness			
Numbness			
Swelling			

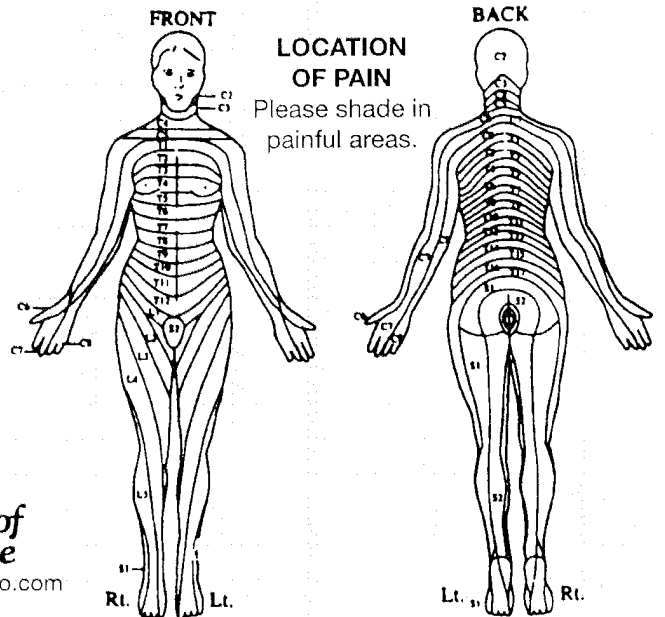
Popping in Joint

Was joint ever dislocated? Yes No Decreased range of motion? Yes No

Do you have a lump that you can feel? Yes No

Do you have arthritis? Yes No Type: _____

FOR TECHNOLOGIST USE ONLY:
Exam Ordered: _____
Reason for Scan: _____



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All medical procedures carry an element of risk and MRI is no exception. The use of contrast material may provide additional information to evaluate your condition and improve the quality of your examination. The most common adverse experience noted by patients receiving contrast is headache and nausea. Additional adverse events occur in less than 1% of patients. Your physician has considered the risks before recommending this exam and believes the diagnostic benefits outweigh the minimal risks suggested.

I HAVE READ THE ABOVE AND GIVE MY CONSENT TO THE PERFORMANCE OF THE MRI PROCEDURE ORDERED, INCLUDING THE ADMINISTRATION OF CONTRAST MATERIAL IF INDICATED.

PATIENT NAME (PLEASE PRINT): _____ E-MAIL: _____

SIGNATURE OF PATIENT/GUARDIAN: _____ DATE: _____

PATIENT UNABLE TO SIGN DUE TO: _____

PERSON COMPLETING FORM: _____ RELATIONSHIP: _____

The following items can interfere with a MRI study. Some could be hazardous to your safety during a MRI scan. **PLEASE ANSWER EVERY QUESTION CAREFULLY!** NOTE: Please remove earrings, necklaces, watches, dentures, and articles in your pockets. (We have lockers to accommodate these items.)

DO YOU HAVE:	YES	NO	COMMENTS
Neurostimulator (TENS unit) or electrode implant?			
Electronic implant or device?			
Magnetically activated implant or device?			
Spinal cord stimulator?			
Bone growth/bone fusion stimulator?			
Insulin or other infusion pump?			
Implanted drug infusion device?			
Cardiac (heart) pacemaker or defibrillator?			
Swan-Ganz or thermodilution catheter?			
Known or possible metal fragments in the eye, head, or body (i.e., welders, machinists, sheet metal workers, etc.)?			
Any heart surgery?			
Prosthetic heart valve?			
Prior vascular surgery?			
Stent, filter or coil?			
Vascular access port and/or catheter?			
Prior brain surgery?			
Aneurysm clips?			
Shunt (spinal or ventricular)?			
Ear surgery/middle ear prosthesis (implant)?			
Eyelid spring or wire/orbital (eye) prosthesis (implant)?			
Hearing aid?			
Dentures?			
If yes, are they held in place with magnets?			
Permanent tattoo, permanent eyeliner or metallic eye shadow?			
Body piercing jewelry?			
IUD (intrauterine device)?			
Known or possible pregnancy?			
Breast feeding?			
Radiation seeds or implants?			
Medication patch (nicotine, nitroglycerine)?			
Wire mesh implant?			
Tissue expander (elg. breast)?			
Surgical staples, clips, or metallic sutures?			
Penile implant, metal rod, pin, screw, nail, wire, plate, etc.?			
Joint or limb replacement?			
War injury or gunshot wound? BBs: bullets?			
Seizures?			
Blood/kidney/liver/respiratory disorder?			
Allergies to drugs?			
Previous reaction to contrast material?			
Asthma or emphysema?			
Do you have a history of cancer?			
Surgery in last 6 weeks?			

Do you have any other medical problems? Please List:

History of other surgeries. Please list:
