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Advanced Imaging

MRI PATIENT INTERVIEW

Male _____ Female_____

Scheduled with _____ **Pregnant Y N**

Date of Exam _____ Phone _____ Patient Name _____

DOB _____ Weight _____ Referring Physician _____

Insurance Carrier _____ Referring Physician Phone _____

Exam _____ Clinical Hx & Information _____

Hx of Ca _____ Type _____ Previous Surgery _____

Previous Xrays Y N When & Where _____

Previous CT/MRI Y N When & Where _____

Do you have or have had any of the following?

Pacemaker	Y	N	Tattooed Eyeliner	Y	N	Ear Surgery	Y	N
Heart Surgery	Y	N	Dentures/Partials	Y	N	Hearing Aides	Y	N
Chest Surgery	Y	N	Shrapnel	Y	N	Possibly Pregnant	Y	N
Brain Surgery	Y	N	Bullets, Shot, BBs	Y	N	Implants	Y	N
Aneurysm Clips	Y	N	Stents or Shunts	Y	N	Claustrophobic?	Y	N

HAVE YOU EVER BEEN STRUCK IN THE EYE WITH ANY TYPE OF METAL SHAVING? Y N

Currently on Medication? Y N If Yes, what type _____

Radiologist Protocol ❑ Routine _____

❑ Non-routine _____

Often times it is necessary to give patients an intravenous injection of MR contrast agent. This contrast does not contain iodine.
Do you have any allergies, asthma, or chronic respiratory problems? Y N

List of Allergies: _____

Parent/Guardian Signature Date Technologist Signature

PLEASE BRING THIS FORM WITH YOU TO YOUR APPOINTMENT ON _____ AT_____AM/PM

With	W/O	Contrast MRI		
☐	☐	Brain		
☐	☐	Skull Base / Face		
☐	☐	Neck (soft tissue)		
☐	☐	C – Spine		
☐	☐	T – Spine		
☐	☐	L – Spine		
☐	☐	Shoulder	R	L
☐	☐	Elbow	R	L
☐	☐	Wrist	R	L

With	W/O	Contrast MRI		
☐	☐	Upper Ext.(non-joint)	R	L
☐	☐	Hip	R	L
☐	☐	Knee	R	L
☐	☐	Ankle	R	L
☐	☐	Cardiac/heart		
☐	☐	Foot	R	L
☐	☐	Lower Ext.(non-joint)	R	L
☐	☐	Chest		
☐	☐	Abdomen		

With	W/O	Contrast MRI
☐	☐	Pelvis
✓	✓	**MRI ANGIOGRAPHY**
☐	☐	Head (circle of Willis)
☐	☐	Neck (carotid)
☐	☐	Chest
☐	☐	Renal Abd. Mesenteric
☐	☐	Pelvis
☐	☐	Extremity (specify)

Miscellaneous Procedure / Comments _____

Physician's Signature Date