



NAME: _____ DATE OF BIRTH: _____ WEIGHT: _____

REASON FOR MRI AND/OR SYMPTOMS: _____

1. Have you ever had prior surgery to the body part being examined today? No Yes
If yes, please indicate the date and type of surgery:

Date: _____ Type: _____

2. Have you had a prior diagnostic imaging study or examination of this part, (CT, MRI, XRay, etc)? No Yes
If yes, please indicate where:

LMR Imaging Radiology Regional Lee Memorial Hospital Cape Coral Hospital
 Health Park Summerlin Imaging SWFL Regional Hospital Other: _____

3. Do you have numbness in your arms or legs? No Yes
If yes, where? _____

4. Have you ever been diagnosed with Cancer? No Yes
If yes, what kind and when? _____



WARNING: Certain implants, devices, or objects may be hazardous to you in the MR environment or MR system room. Do not enter the MR environment or MR system room if you have any question or concern regarding an implant, device, or object. Please consult the MRI Technologist or Radiologist if you have any question or concern BEFORE you enter the MR system room

Please indicate if you have any of the following:

- | | | | |
|--|--|--|---------------------------------|
| <input type="checkbox"/> No <input type="checkbox"/> Yes | Aneurysm clip(s)/Aneurysm | <input type="checkbox"/> No <input type="checkbox"/> Yes | Hypertension |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | Cardiac pacemaker | <input type="checkbox"/> No <input type="checkbox"/> Yes | Diabetes |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | Implanted cardioverter defibrillator (ICD) | <input type="checkbox"/> No <input type="checkbox"/> Yes | Buerger's Disease |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | Electronic implant or device | <input type="checkbox"/> No <input type="checkbox"/> Yes | PVD (peripheral vascular ds) |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | Magnetically-activated implant or device | <input type="checkbox"/> No <input type="checkbox"/> Yes | Embolism in leg(s) |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | Neurostimulation system | <input type="checkbox"/> No <input type="checkbox"/> Yes | Chance of Pregnancy |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | Spinal cord stimulator | <input type="checkbox"/> No <input type="checkbox"/> Yes | TIA/Stroke |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | Internal electrodes or wires | <input type="checkbox"/> No <input type="checkbox"/> Yes | Heart valve prosthesis |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | Bone growth/bone fusion stimulator | <input type="checkbox"/> No <input type="checkbox"/> Yes | Metallic stent, filter, or coil |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | Cochlear, otologic, or other ear implant | <input type="checkbox"/> No <input type="checkbox"/> Yes | Joint replacement (hip, knee) |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | Insulin or other infusion pump | <input type="checkbox"/> No <input type="checkbox"/> Yes | Sickle Cell |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | Any type of prosthesis (eye, penile, etc.) | <input type="checkbox"/> No <input type="checkbox"/> Yes | Metal slivers/shrapnel in eye |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | Breathing problem or motion disorder | <input type="checkbox"/> No <input type="checkbox"/> Yes | Tissue expander (e.g., breast) |

Do you have both of your kidneys? Y N Are they functioning well? Y N
If NO, have you had recent blood work to evaluate them? Y N When/Where? _____

IMPORTANT INSTRUCTIONS

Before entering the MR environment or MR system room, you must remove all metallic objects including hearing aids, dentures, partial plates, keys, beeper, cell phone, eyeglasses, hair pins, barrettes, jewelry, body piercing jewelry, watch, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools, clothing with metal fasteners, & clothing with metallic threads. Please consult the MRI Technologist or Radiologist if you have any question or concern BEFORE you enter the MR system room.

NOTE: You may be advised or required to wear earplugs or other hearing protection during the MR procedure to prevent possible problems or hazards related to acoustic noise.

- I attest that the above information is correct to the best of my knowledge. I have read and understand the entire contents of this form and have had the opportunity to ask questions regarding the information on this form.

Signature of Person Completing Form: _____ Date ____/____/____

Staff Use Only: Contrast amount Used: _____ Contrast Amount Wasted: _____