FLORIDA RADIOLOGY CONSULTANTS
Your choice for advanced health imaging

MRI Medical History

NAME:_____ DATE OF BIRTH:_____WEIGHT:_____

REASON FOR MRI AND/OR SYMPTOMS:

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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:

□ Florida Radiology □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? _____

Do you have both of your kidneys? □ **Yes** □ **No**
Are they functioning well? □ **Yes** □ **No**
If *NO*, have you had recent blood work to evaluate them? □ **Yes** □ **No**

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.

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:

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

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 _____/_____/_____