Advanced Open Imaging
Imaging & Vein Centers of Idaho

Patient Name:_____ **MR#**_____

DOB:_____

MUSIC STATION #_____

Symptoms: _____

Weight: _____

_____

Do you weigh in excess of 350 pounds? ☐ **yes** ☐ **no**

_____

Height: _____

Please list all surgeries or operations you have had in your lifetime.

Date: _____ **Surgery:** _____

Date: _____ **Surgery:** _____

Date: _____ **Surgery:** _____

Date: _____ **Surgery:** _____

Date: _____ **Surgery:** _____

Date: _____ **Surgery:** _____

Date: _____ **Surgery:** _____

Date: _____ **Surgery:** _____

Date: _____ **Surgery:** _____

Date: _____ **Surgery:** _____

Have you ever had an IMAGING study of the SAME BODY PART we are examining today? **NO**_____ **YES**_____

IF YES PLEASE LIST:	**Date**	**Facility**
MRI		
CT		
US		
XRAY		
OTHER		

WARNING: Certain implants, devices or objects may be hazardous to you and/or may interfere with the MRI procedure. **DO NOT ENTER** the MRI system room or MRI environment if you have any questions or concern regarding an implant device or object. Consult the MRI Technologist or Radiologist **BEFORE** entering the MRI system room. **THE MRI MAGNET IS ALWAYS ON.**

YES NO

- ☐ ☐ HAVE YOU EVER HAD AN INJURY TO THE EYE INVOLVING A METALLIC OBJECT OR FRAGMENT?
- ☐ ☐ ARE YOU CURRENTLY IN RENAL FAILURE OR ON DIALYSIS, HAVE KIDNEY PROBLEMS OR RENAL INSUFFICIENCY?
- ☐ ☐ ARE YOU DIABETIC?
- ☐ ☐ DO YOU OR HAVE YOU HAD A CARDIAC PACEMAKER?
- ☐ ☐ DO YOU HAVE AN IMPLANTED CARDIAC DEFIBRILLATOR?
- ☐ ☐ DO YOU HAVE AN IMPLANTED BIO STIMULATOR OR TENS UNIT?
- ☐ ☐ DO YOU HAVE OR HAVE YOU HAD A COCHLEAR (INNER EAR) IMPLANT?

PLEASE INDICATE IF YOU NOW HAVE OR HAVE EVER HAD ANY OF THE FOLLOWING:

YES NO

- ☐ ☐ RADIATION SEEDS OR IMPLANTS
- ☐ ☐ SWAN-GANZ OR THERMODILUTION CATHETER
- ☐ ☐ ANEURYSM CLIP(S)
- ☐ ☐ CANCER: TYPE/DATE: _____
- ☐ ☐ ELECTRONIC IMPLANT/DEVICE
- ☐ ☐ MAGNETIC IMPLANT DEVICE
- ☐ ☐ NEUROSTIMULATION SYSTEM
- ☐ ☐ INTERNAL ELECTRODES/WIRES
- ☐ ☐ BONE GROWTH/FUSION STIMULATOR
- ☐ ☐ TEMPERATURE FOLEY
- ☐ ☐ EAR IMPLANT TYPE: _____
- ☐ ☐ INSULIN/INFUSION PUMP
- ☐ ☐ IMPLANTED DRUG INFUSION DEVICE
- ☐ ☐ ARTIFICIAL/PROSTHETIC LIMB
- ☐ ☐ HEART VALVE PROSTHESIS
- ☐ ☐ MEDICATION PATCH (NICOTINE, NITROGLYCERINE, ETC.)
- ☐ ☐ PROSTHESIS (ANY TYPE)

YES NO

- ☐ ☐ HEARING AID (MUST REMOVE)
- ☐ ☐ EYELID SPRING/WIRE
- ☐ ☐ STENT/FILTER/COIL: LOCATION _____
- ☐ ☐ SPINAL/INTERVENTRICULAR SHUNT
- ☐ ☐ VASCULAR ACCESS PORT/CATHETER
- ☐ ☐ ANY METALLIC FRAGMENT/FOREIGN BODY
- ☐ ☐ TISSUE EXPANDER (E.G. BREAST)
- ☐ ☐ SURGICAL STAPLES/CLIPS/SUTURES
- ☐ ☐ JOINT REPLACEMENT (HIP/KNEE/ETC.)
- ☐ ☐ BONE OR JOINT PIN/SCREW/NAIL/PLATE
- ☐ ☐ DENTURES OR PARTIAL PLATES
- ☐ ☐ TATTOOS OR PERMANENT MAKEUP
- ☐ ☐ BODY PIERCING JEWELRY
- ☐ ☐ OTHER IMPLANT: _____
- ☐ ☐ ARE YOU CLAUSTROPHOBIC? IF SO ANSWER THE FOLLOWING

  *DID YOU SELF MEDICATE?*_____

  TYPE OF MEDICATION: _____

FOR FEMALE PATIENTS

YES NO

- ☐ ☐ ARE YOU PREGNANT OR EXPERIENCING A LATE MENSTRUAL PERIOD? DATE OF LAST PERIOD: _____
- ☐ ☐ ARE YOU POSTMENOPAUSAL?
- ☐ ☐ ARE YOU CURRENTLY USING AN IUD, DIAPHRAGM OR PESSARY?
- ☐ ☐ ARE YOU TAKING ORAL CONTRACEPTIVES OR RECEIVING HORMONAL TREATMENT? _____
- ☐ ☐ ARE YOU CURRENTLY BREAST FEEDING

- **Please notify the center *IMMEDIATLY* if any of the following apply:**
  ___Pacemaker ___Aneurysm Clips ___Incident of Metal in the eye(s) ___Shrapnel ___Stents
- Please consult the MRI Technologist or Radiologist if you have any questions or concerns BEFORE you enter the MRI system room.
- The MRI procedure you have been scheduled for may require the intravenous injection of a non-iodinated contrast solution. It is used to enhance the ability of MRI to facilitate diagnosis. While there are no known contraindications, mild side effects including nausea or slight headaches may occur. This solution is not the same used for CT scans or angiography.
- I attest that the above information is correct to the best of my knowledge. I read and understand the entire contents of this form and I have had the opportunity to ask questions regarding the information on this form.

SIGNATURE OF PERSON COMPLETING FORM: _____

RELATIONSHIP: _____ **DATE**: _____