RAI PATIENT HISTORY MRI BRAIN: **Techs/Tech Aide:_____**

Today's Date:_____Patient Scanned for Metal: ☐ Yes ☐ No RAI Tech:_____

Name: _____Age:_____Weight:_____Referring Physician:_____

1. Describe your current problems/symptoms:_____

_____Length of symptoms: _____

2. Describe any prior or existing medical conditions (high blood pressure, stroke, bleed, aneurysm, diabetes):

_____

3. Have you been diagnosed with cancer? Circle: Y - N Please provide type and location (ex. Brain, melanoma on left shin; breast cancer, right upper inner quadrant) _____

4. Prior surgery/biopsy related to cancer: Site _____ Facility _____
Date _____

5. Treatments related to cancer:
Chemo – if yes, date of last treatment_____ provide date of any future treatments planned _____

Radiation – if yes, date of last treatment_____ provide date of any future treatments planned _____

6. Any Brain surgery? Circle: Y – N When? _____What was done? _____

7. Do you get headaches? Circle: Y - N
If yes, circle type of headaches: Cluster - Vascular - Tension - Post Trauma – Drug induced - Exertional

8. Do you get migraine headaches? Circle: Y – N If yes, circle type of migraines: Migraine variant - Recent migraine - Intractable migraine
Other type of migraine:_____(if known)

9. Do you have hearing loss? Circle: Y - N Which side of your body? (Circle One) Right Left Bilateral (Right and Left)

10. List ALL current medications: _____

11. Do you have any known allergies? _____

12. If Injury/Accident/MVA –

a. Exact Location (ex. Ear, cheek, scalp, forehead, eye): _____

b. Type of Injury/Symptoms (Circle One): 1. Abrasion 2. Contusion 3. Laceration/Open Wound 4. Penetrating
5. Foreign Body 6. Swelling 7. Other_____

c. Which side of your body? (Circle): Right Left Bilateral (Right and Left)

13. <u>Prior Diagnostic Imaging: Brain Studies (CT/MRI):</u>

Study/Date/Facility:_____

_____

14. Have you experienced any problem related to a previous MR examination or MR procedure? Yes - No

If yes, please describe: _____

15. Have had an injury to the eye involving a metallic object or foreign body (i.e.: metallic slivers, shavings, foreign body, etc.)?
Yes - No If yes, please describe: _____

16. Have you ever been injured by a metallic object or foreign body (i.e.; BB, bullet, shrapnel, etc.)? Yes - No
If yes, please describe: _____

17. Has your physician prescribed any sedation or medication specifically for this examination? Yes - No
If yes, please describe: _____

18. FOR FEMALE PATIENTS:

1. **Date of last menstrual period: _____ Post-menopausal? Yes - No (Circle which apply)**
2. **Are you pregnant or experiencing a late menstrual period? Yes - No**

Comments:_____

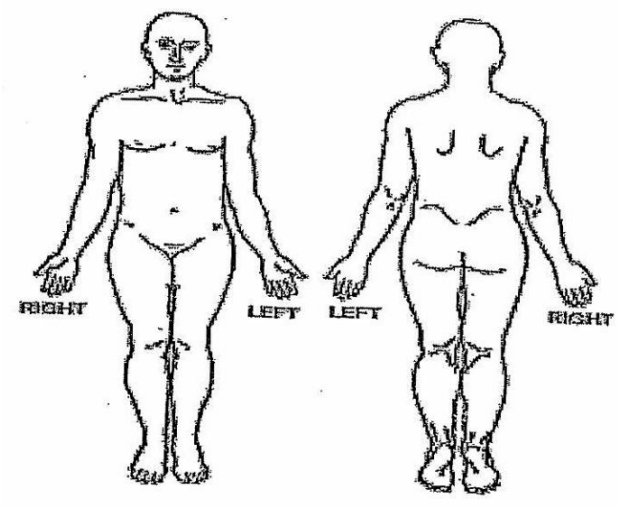
_____**(see back of form)**

WARNING: Certain implants, devices or objects may be hazardous to you and/or may interfere with the MR procedure (i.e. MRI, MR angiography, functional MRI, MR spectroscopy). **Do not enter** the MR system room or MR environment if you have any question or concern regarding an implant, device, or object. Consult the MRI Technologist or Radiologist BEFORE entering the MR system room.
The MR system magnet is ALWAYS on.

Please indicate if you have any of the following:

☐ Yes ☐ No Aneurysm clip(s)
☐ Yes ☐ No Cardiac pacemaker
☐ Yes ☐ No Implanted cardioverter defibrillator (ICD)
☐ Yes ☐ No Electronic implant or device
☐ Yes ☐ No Magnetically-activated implant or device
☐ Yes ☐ No Neurostimulation system
☐ Yes ☐ No Spinal cord stimulator
☐ Yes ☐ No Internal electrodes or wires
☐ Yes ☐ No Bone growth/bone fusion stimulator
☐ Yes ☐ No Cochlear, otologic, or other ear implant
☐ Yes ☐ No Any type of prosthesis (eye, penile, etc.)
☐ Yes ☐ No Heart valve prosthesis
☐ Yes ☐ No Eyelid spring or wire
☐ Yes ☐ No Artificial or prosthetic limb
☐ Yes ☐ No Metallic stent, filter, or coil
☐ Yes ☐ No Shunt (spinal or intraventricular)
☐ Yes ☐ No Vascular access port and/or catheter
☐ Yes ☐ No Radiation seeds or implants
☐ Yes ☐ No Swan-Ganz or thermodilutin catheter
☐ Yes ☐ No Medication patch (Nicotine, Nitroglycerine, birth control)
☐ Yes ☐ No Any metallic fragment or foreign body (bullet, pellets, shrapnel)
☐ Yes ☐ No Any wire mesh implant
☐ Yes ☐ No Tissue expander (e.g., breast)
☐ Yes ☐ No Surgical staples, clips, or metallic sutures
☐ Yes ☐ No Joint replacement (hip, knee, etc.)
☐ Yes ☐ No Bone/joint pin, screw, nail, wire, plate, etc.
☐ Yes ☐ No IUD, diaphragm, or pessary
☐ Yes ☐ No Dentures or partial plates
☐ Yes ☐ No Tattoo or permanent makeup
☐ Yes ☐ No Body piercing jewelry
☐ Yes ☐ No Hearing aid *(Remove before entering the MR system room)*
☐ Yes ☐ No Other implant_____
☐ Yes ☐ No Breathing problem or motion disorder
☐ Yes ☐ No Claustrophobia

Please mark on the figure(s) below the location of any implant or metal inside of OR on your body.



IMPORTANT INSTRUCTIONS

Before entering the MR environment or MR system room you must remove <u>all</u> 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. MRI is generally a safe procedure. Qualified medical personnel will be present throughout the entire procedure. The FDA has determined that MRI presents no great risk.

I attest that all information provided is correct to the best of my knowledge and that I will not bring any type of metallic objects into the MRI room including but not limited to hearing aids, weapons, watches, electronics, etc. I read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and regarding the MR procedure that I am about to undergo. I understand I cannot hold Radiology Affiliates liable for injury or loss of personal property due to my own negligence.

Signature of Person Completing Form:_____ Date:_____

Form Completed By: ☐ Patient ☐ Relative ☐ Other_____ _____
Print name Relationship to Patient

Form Information Verified by:_____ _____
Print name Signature