

**RAI PATIENT HISTORY MRI CHEST/ABDOMEN/PELVIS:**

**Technologist/Tech Aide:** \_\_\_\_\_

**Today's Date:** \_\_\_\_\_ **Patient Scanned for Metal:**  Yes  No **RAI Tech:** \_\_\_\_\_

**Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Weight:** \_\_\_\_\_ **Referring Physician:** \_\_\_\_\_

**1. What part of the body will be scanned today:** \_\_\_\_\_

**2. Describe your current problems/symptoms:** \_\_\_\_\_  
Length of symptoms: \_\_\_\_\_

**3. Any surgery on area being scanned: Circle: Y – N Type?** \_\_\_\_\_ **When?** \_\_\_\_\_

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

**5. Prior surgery/biopsy related to cancer: Site** \_\_\_\_\_ **Facility** \_\_\_\_\_  
**Date** \_\_\_\_\_

**6. 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** \_\_\_\_\_  
**Other treatment – please describe and provide dates:** \_\_\_\_\_

**7. Describe any existing medical conditions (high blood pressure, diabetes):**  
\_\_\_\_\_

**8. List ALL current medications:** \_\_\_\_\_

**9. Do you have any known allergies?** \_\_\_\_\_

**10. If Injury/Accident/MVA –**

**a. Exact Location** (ex. Anterior chest wall, muscle, abdomen): \_\_\_\_\_

**b. Type of Injury/Symptoms** (Circle One): 1. Sprain 2. Strain 3. Abrasion 4. Contusion 5. Crush Injury 6. Laceration  
6. Penetrating 7. Other \_\_\_\_\_

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

**10. Prior Diagnostic Imaging: Chest/Abdomen/Pelvis Studies (XRAY/US/CT/MRI):**

**Study/Date/Facility:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**12. Have you experienced any problem related to a previous MR examination or MR procedure?** Yes - No  
If yes, please describe: \_\_\_\_\_

**13. Have you had an injury to the eye involving a metallic object or fragment (i.e.; metallic slivers, shavings, foreign body, etc.)?** Yes - No  
If yes, please describe: \_\_\_\_\_

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

**15. Has your physician prescribed any sedation or medication specifically for this examination?** Yes - No  
If yes, please indicate type and amount \_\_\_\_\_

**16. 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)

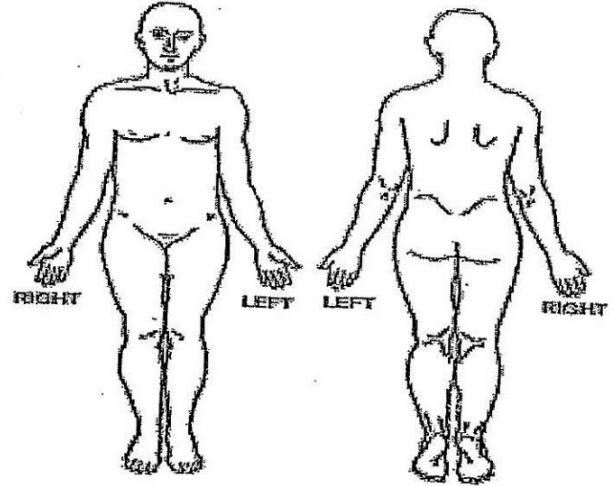


**WARNING:** Certain implants, devices or objects may be hazardous to you and/or may interfere with the MR procedure (i.e. MRI, MR angiography, functional MRI, MR spectroscopy). **Do not enter** the MR system room or MR environment if you have any question or concern regarding an implant, device, or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



<b>!</b>	<b>IMPORTANT INSTRUCTIONS</b>
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**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. 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