

MRI PATIENT REGISTRATION FORM

Patient Name	Date	Date of Birth	Age	Sex	Height	Weight
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Type of MR exam today: _____ Why are you having this exam (Describe current problem): _____

• Have you had a previous MRI? No Yes When? _____ Where? _____

What did it show? _____

• Have you had another type of study (i.e., CT, US, X-Ray, Nuclear Medicine) which pertains to your current problem? No Yes

When? _____ Where? _____ What did it show? _____

• List any operations you have had and the dates: _____

• Do you have a history of cancer? No Yes If yes, what type of cancer? _____

• Did you undergo surgery for this? No Yes When? _____

• Did you receive radiation therapy? No Yes When? _____

• Did you receive chemotherapy? No Yes When? _____

• Do you have a history of any of the following medical problems?

Anemia/Blood Disorder No Yes Diabetic No Yes Seizures No Yes

Kidney Disease No Yes Stroke No Yes

Heart Disease No Yes Serious Head Injury No Yes

High Blood Pressure No Yes Other (please specify) _____

• Current Medications: _____

• List all allergies (including drug allergies): _____

• Have you ever had a reaction to IV contrast material (Iodine) given during a previous CT scan/IVP/Angiogram? No Yes

If yes, explain: _____

• Have you ever had a reaction to IV contrast material (Gadolinium) given during a previous MRI examination? No Yes

If yes, explain: _____

• Female patients:

Are you pregnant, or could you possibly be pregnant? No Yes

Are you breast feeding: No Yes

Date of last menstrual period _____ post-menopausal? No Yes

Are you taking oral contraceptives or hormonal replacement? No Yes

Please indicate if you have the following: Cardiac Pacemaker No Yes

Implanted Cardiac Defibrillator No Yes



If yes to either of these two above, then MRI cannot be done.

No Yes Neuro Stimulator/Spinal fusion Stimulator No Yes Transdermal Medication Patch (If yes, patch must be removed)

No Yes Cerebral Aneurysm Clip No Yes Vascular Stent, Filter, Coil or Clamp

No Yes Metal Fragments (eye, head, skin, etc.) No Yes Vascular Access Port and/or Catheter

No Yes Implanted Drug Infusion Pump No Yes Swan Ganz Catheter

No Yes Cochlear, Otologic or Ear Implant No Yes Intraventricular or Spinal Shunt

No Yes Internal Cardiac Pacing Wires No Yes Wire Mesh

No Yes Magnetically Activated Implant No Yes IUS/Diaphragm

No Yes Heart Valve Prosthesis No Yes Tattoo or Tattooed Eyeliner

No Yes Ornamental Body Piercing No Yes Any Surgical Clips or Staples

No Yes Prosthesis (orbital, limb, penile, etc.) No Yes Hearing Aid/Dentures

No Yes Orthopedic Implant (pins, plates, rods, screws, joint replacement)

Any other implanted item? If yes, describe: _____

List the details of any item with a “yes” response (i.e., exact implant, model#, etc.) _____

- You will be asked to remove all jewelry (except rings), watches, hairpins or other hair ornaments, hearing aids, removable dental work, and eye make-up. Purses, wallets, money clips, coins, and credit cards are not allowed in MRI. Hospital gown and pants MUST be worn (no bras).
- We strongly recommend the use of earplugs.
- I attest the above information is correct to the best of my knowledge and have had the opportunity to ask questions regarding the information on this form.

Patient signature: _____

Patient approved for MR procedure? No Yes

MRI Technologist’s signature: _____ Date: _____