

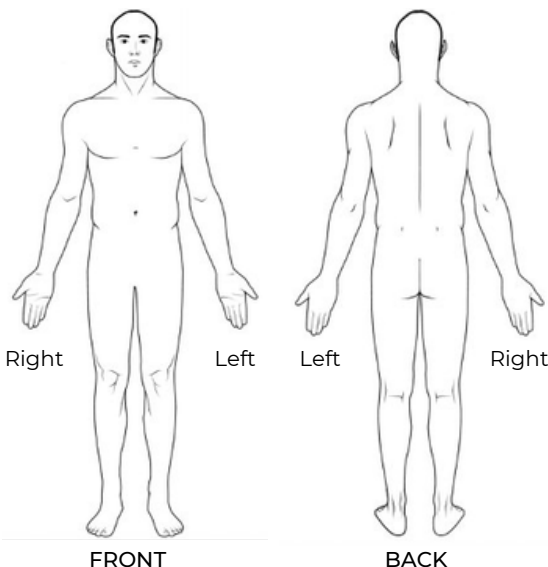
PATIENT'S NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

ALLERGIES: \_\_\_\_\_ WEIGHT: \_\_\_\_\_

**MARK WITH "X"**

- |                          |                          |   |
|--------------------------|--------------------------|---|
| YES                      | NO                       | Is there any possibility you may be pregnant?   |
| <input type="checkbox"/> | <input type="checkbox"/> | If YES, how many weeks? _____   |
|                          |                          | If NO, date of last period _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you breast feeding?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a problem with claustrophobia?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever done any welding or grinding?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you in your lifetime, gotten any metal fragments or shavings in your eyes, face, ears, or extremities? (PLEASE CIRCLE) When? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had cancer of any type? If YES, what type? _____<br>When? _____   |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had radiation or chemotherapy? If YES, on what part of your body?<br>_____   |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have a history of diabetes, hypertension, liver disease, recurrent urinary tract infections, or possible kidney disease?         |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had surgery? If YES, what procedure & when?<br>_____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had surgery? If YES, what procedure & when?<br>_____<br>_____   |

Please describe the current problems that you are having & list any prior studies or procedures related to this (you may use pictures below):



\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**\*CONTRAINDICATIONS**

**PATIENT LABEL**

No MRI if the following:

- Pacemaker
- Implanted insulin / drug pump
- swan ganz catheter
- neurostimulator (tens unit)
- biostimulator

\*Need stent document prior to MRI

\*Patients must have IV pumps removed before MRI exam