IMAGECARE MRI

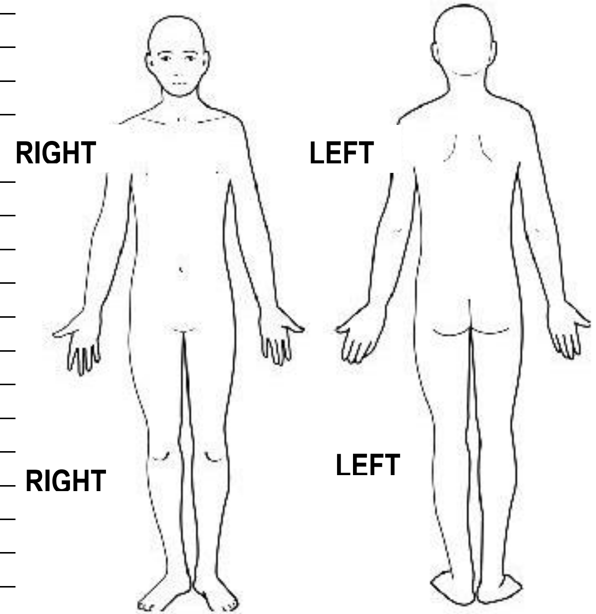
PATIENT NAME__________________________________ Date of Birth_________Age_____Weight____Ht__

Are you Right handed_____ Left handed_____ : Smoker____ Non-Smoker____Ex-Smoker____

There is a strong magnetic field used with MRI which can affect the operation of electric and mechanical devices and can be potentially hazardous to your safety.

Do you have a history of: (please circle Yes or No) ***If yes, please explain***

Cardiac Pacemaker	**Y N**	________________________
Implanted Cardioverter Defibrillator	**Y N**	________________________
Brain Aneurysm Clips	**Y N**	________________________
Brain or Inner Ear Surgery	**Y N**	________________________
Cochlear Implants	**Y N**	________________________
Electric Pumps or Implants	**Y N**	________________________
Transdermal Patch	**Y N**	________________________
Surgical Pins, Rods, Clips	**Y N**	________________________
Hearing Aid	**Y N**	________________________
Heart or Lung Surgery	**Y N**	________________________
Artificial Joint or Limb	**Y N**	________________________
Metal Fragments or Shrapnel	**Y N**	________________________
History of Metal Injury to Eyes	**Y N**	________________________
Dentures or Dental Prosthesis	**Y N**	________________________
Permanent Eyeliner	**Y N**	________________________
Are you Breastfeeding	**Y N**	________________________
Diabetes	**Y N**	________________________
History of Kidney Disease or Dialysis	**Y N**	________________________
History of Liver transplant	**Y N**	________________________
Personal History of Cancer	**Y N**	________________________
Radiation or Chemotherapy	**Y N**	________________________
Hypertension	**Y N**	________________________
Sickle Cell Disease	**Y N**	________________________
Previous or related testing of this area	**Y N**	**if yes : WHERE AND WHEN**



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Any surgery to the area being scanned Y N if yes : PLEASE EXPLAIN AND INCLUDE DATE

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**** MRI is not currently FDA approved for pregnant females.**

Initial here if you believe you are not pregnant_______ Last menstrual period_________

****Is this exam related to Workers Comp or No Fault? Y N**

****Please describe your symptoms below. Be very specific about your primary complaint (pain, numbness, etc. and where it radiates). Include as much information as possible. Also include where the symptoms are occurring, and if it is your Right or Left side. (Please show on body diagram above.)**

ALL PATIENTS, PLEASE READ AND SIGN **It is imperative that you leave all magnetic items outside of the magnet room. The magnet is strong enough to alter the operation of watches, calculators, etc. The magnet will also erase credit cards and bank cards. Please leave these items in the locker provided.**

Signature: ____ Date:__________ Ear Plugs________

Technologist notes only:

Screened By_____ Scanned By_____ Pacs list______Nuance_____ MDM_____Ear Plugs______