

MAGNETIC RESONANCE SCREENING

Because of the presence of a strong magnetic field, it is important that we are aware of any metallic objects that have been surgically placed in the body. Therefore, an accurate surgical and medical history is needed.

When is your follow up appointment with your doctor? _____ What is your weight and height? _____

Have you ever had dialysis? Yes No Do you have a history of liver disease or liver transplant? Yes No

Do you have any of the following? Check all that apply:

Kidney disease Sickle cell anemia Heart disease Multiple myeloma High blood pressure
 Multiple sclerosis Advanced congestive heart failure (CHF) Diabetes

Are you on any medication your doctor has told you could affect your kidney function? Yes No

Have you been treated with any chemotherapy agents? Yes No Are you on IV antibiotics? Yes No

Do you have medication allergies? If yes, please list: _____

Do you have a known allergy to MRI contrast (gadolinium)? Yes No

Have you had MRI contrast (gadolinium) administered before? Yes No If yes, was it within the last 48 hours? Yes No

Please check if you have any of the following:

Cardiac Pacemaker	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Implanted Cardiac Defibrillator	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Valve Replacement	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Bypass Surgery	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Stent Placement	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Aneurysm or Aortic Clip/Coils	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Neurostimulator	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Implanted Pumps	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Carotid Sinus Stimulation Device	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Shunt	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Deep Brain Stimulator	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Vagus Nerve Stimulator	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Occular (eye) Implant	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cochlear (ear) Implant	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hearing Aids	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Joint Replacements	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Artificial Limbs	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Wire Sutures	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Harrington Rods	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fractured Bones treated with screws, pins, or any metal	<input type="checkbox"/> Yes	<input type="checkbox"/> No
IVC Filter	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Swan-Ganz or Thermodilution Catheter	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Temperature Sensing Foley Catheter	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Tattoo/Cosmetic tattoo? Yes No

Have you had a tattoo removed? Yes No

Medication Patches or Dressings containing Silver Yes No

Are you wearing creams/lotions containing silver? Yes No

Any other metal implants? Yes No

History of Cancer? Yes No

History of Tumor? Yes No

Removable Dental Work Yes No

Body Piercings Yes No

Shrapnel/bullet fragments Yes No

Have you ever grinded/welded with metal or had metal in eyes? Yes No

For men only:

Penile Implant Yes No

Prostate Seeds Yes No

For Women only:

Are you pregnant? Yes No

Are you breast feeding? Yes No

IUD Yes No

Breast Tissue Expander/Pump Yes No

Have you ever had surgery on the part of the body we will be examining? If yes, please explain:

Have you had prior imaging studies of the body part we are imaging today? (X-ray, CT, MRI)

If yes, kind of study: _____ where? _____ when? _____

Signature _____ Date _____

Name of person filling out this form if other than patient (please print) _____

Relationship to patient (please print) _____

PATIENT LABEL

FIRST HILL DIAGNOSTIC IMAGING

A Swedish Medical Imaging Center

SEATTLE, WASHINGTON

Form 70993 Nonstock Rev. 3/12/10 CC