Monticello Diagnostic Imaging
A Service of Wise Regional Health System

MRI Health History

Patient Name:_____ Today's Date:_____

DOB: _____ Sex: M F

Height:_____ Weight:_____

Do you have a cardiac pacemaker?
Yes No

Do you have brain aneurysm clips?
Yes No

Do you have cochlear ear implants?

Yes No

Have you ever had cancer?

Yes No
If yes, what kind? _____

Have you had brain surgery?

Yes No
Date:_____

Have you had prior MRI/CT studies?

Yes No
Date:_____
Type:_____

Have you had a piece of metal removed from your eye(s)?

Yes No

Do you have allergies, kidney disease, or Sickle Cell Anemia?

Yes No

Do you have dentures or partial plates?

Yes No

Do you have:

Severe kidney insufficiency Yes No

Ever had a liver transplant Yes No

Chronic liver disease Yes No

The following may be hazardous or may interfere with the exam.

Please mark yes or no and date of surgery.

Y N Heart Surgery_____

Y N Internal Defibulator _____

Y N Aortic Clips _____

Y N Carotid Clips _____

Y N Neurostimulators _____

Y N Bio stimulator _____

Y N Heart Valve _____

Y N Insulin Pump _____

Y N Stents _____

Y N Shunts _____

Y N Joint Replacements/Bone Pins/Metal Rods/Plates _____

Y N Coils or Filters _____

Y N Retinal Tac Implant _____

Y N Shrapnel/Metal Injuries_____

Y N Skin Patch Drugs _____

Y N Pain Pump _____
Do you have your card with you?

ARE YOU CLAUSTROPHOBIC?

YES NO

Are you or could you be pregnant?
Yes No

**** The FDA has indicated that safety of MR Imaging on the fetus has not been established or proved.***

Are you breastfeeding?
Yes No
(If yes, no breastfeeding for 24 hours)

Do you have any body parts pierced?
Yes No

Are you currently or have you been on dialysis? Yes No

Do you wear hearing aids?
Yes No

***THE TECHNOLOGIST WILL HAVE YOU CHANGE INTO A GOWN IF NECESSARY FOR YOUR TEST.**

Please describe your symptoms:
_____

_____

_____

_____

How long have they been present?
_____

Were your symptoms caused by an injury? Yes No