Imaging
AUGUSTA UNIVERSITY HEALTH

MRI History Form

PATIENT INFORMATION **Fall Precaution** ☐ YES ☐ NO

Last Name	First Name/Middle Initial	Gender	Race
Date of Birth (MM/DD/YYYY) / /	Age	Height	Weight

PERSONAL HISTORY Please indicate if you have any of the following

☐Yes ☐No	Swan-Ganz or thermodilution catheter	☐Yes ☐No	Shunt (spinal or ventricular)
☐Yes ☐No	Cardiac Pacemaker	☐Yes ☐No	Tissue expander (e.g. breast)
☐Yes ☐No	Implanted Cardioverter defibrillator (ICD)	☐Yes ☐No	Any type of prosthesis (limb, eye, penile, etc)
☐Yes ☐No	Aneurysm Clip(s)	☐Yes ☐No	Metallic Stent, filter, or coil
☐Yes ☐No	Eyelid spring or wire	☐Yes ☐No	IUD, diaphragm, or pessary
☐Yes ☐No	Heart valve prosthesis	☐Yes ☐No	Wire mesh, surgical staples, clips, metallic sutures
☐Yes ☐No	Neuro or Spinal Cord Stimulator	☐Yes ☐No	Medication Patch (Nicotine, Nitroglycerine)
☐Yes ☐No	Internal electrodes or wires	☐Yes ☐No	Tattoo or permanent make-up
☐Yes ☐No	Bone growth / Bone Stimulator	☐Yes ☐No	Dentures or partial plates
☐Yes ☐No	Cochlear, otologic, or other ear implant	☐Yes ☐No	Body piercing jewelry
☐Yes ☐No	Implanted drug/insulin infusion device	☐Yes ☐No	Hearing Aid
☐Yes ☐No	Joint replacement (hip, knee, etc.)	☐Yes ☐No	Any metallic fragment or shavings, BB,
☐Yes ☐No	Bone/joint pin, screw, nail, wire, plate, etc)		shrapnel or foreign body (including eye injuries)
☐Yes ☐No	Any other implant: _____		

Please answer all questions below:

☐Yes ☐No	Seizure Disorder	☐Yes ☐No	High Blood Pressure
☐Yes ☐No	Asthma	☐Yes ☐No	Kidney Disease/ Kidney Failure
☐Yes ☐No	Diabetes	☐Yes ☐No	Dialysis
☐Yes ☐No	Liver Disease	☐Yes ☐No	Heart or Blood Disease

☐Yes ☐No Allergies If yes, please specify: _____

☐Yes ☐No Surgeries If yes, please specify: _____

☐Yes ☐No Cancer If yes, please specify: _____

Have you ever had a reaction to injected MRI contrast? ☐YES ☐NO If yes, please explain: _____

FEMALE PATIENTS ONLY

Some imaging procedures are contra-indicated (not recommended) for patients who may be pregnant. If you may be pregnant, please notify one of our team members. By my signature below, I acknowledge that I have read and understand this statement and state that I am not pregnant and there is no chance that I may be pregnant.

Are you breastfeeding ☐ YES ☐ NO Date of last period: _____

FOR TECH USE ONLY

Contrast: _____ Dose: _____ mL Waste _____ mL Inj. Rat: _____ cc/sec iStat Creatinine: _____

IV Site: R L _____ IV Size: _____ g # Attempts: _____ Initials: _____

ACKNOWLEDGMENT

I have answered these questions to the best of my knowledge and understand the information presented to me. If I am to have intravenous contrast with my procedure, I have been informed of the risks.

_____ _____

PATIENT / GUARDIAN SIGNATURE DATE

_____ _____ FINAL STOP CHECK INTIALS: _____

TECHNOLOGIST SIGNATURE DATE