History Checklist

Open MRI of St. Joseph
Phone: 816-364-4674
Fax: 816-364-2575

1. Have you had a MRI before? ☐ Yes ☐ No
   If yes, was it performed at this location? ☐ Yes ☐ No

2. Who is your referring physician? _____

3. Who is your primary physician? _____

Legal Name: _____ Cell Phone: _____

Birth Date: _____ Weight: _____ Height: _____ Home Phone: _____

Date of Injury: _____ Work Phone: _____

Reason for Exam: _____

Tech. Comments: _____

Patient safety is a primary concern. The following items can interfere with magnetic resonance imaging (MRI) and some can be hazardous to your safety. Please check the following:

☐ Yes ☐ No	Personal history of cancer	☐ Yes ☐ No	Metallic stent, filter or coil
☐ Yes ☐ No	Metal in/around eyes from welding/grinding	☐ Yes ☐ No	Claustrophobia
☐ Yes ☐ No	Brain aneurysm clip(s)	☐ Yes ☐ No	Shrapnel in body
☐ Yes ☐ No	Cardiac pacemaker	☐ Yes ☐ No	Vascular access port and/or catheter
☐ Yes ☐ No	Implanted cardioverter defibrillator (ICD)	☐ Yes ☐ No	Swan-Ganz or thermodilution catheter
☐ Yes ☐ No	Electronic implant or device	☐ Yes ☐ No	Medication patch (Nicotine, Nitroglycerin)
☐ Yes ☐ No	Magnetically-activated implant or device	☐ Yes ☐ No	Wire mesh implant
☐ Yes ☐ No	Shunt (spinal or intraventricular)	☐ Yes ☐ No	Tissue expander (e.g. breast)
☐ Yes ☐ No	Internal electrodes or wires	☐ Yes ☐ No	Surgical staples, clips, or metallic sutures
☐ Yes ☐ No	Cochlear implant or hearing aid	☐ Yes ☐ No	Joint replacement (hip, knee, etc.)
☐ Yes ☐ No	Insulin pump	☐ Yes ☐ No	Dentures or partial plates
☐ Yes ☐ No	Implanted drug infusion device	☐ Yes ☐ No	Tattoo or permanent makeup
☐ Yes ☐ No	Penile implant	☐ Yes ☐ No	Body piercing jewelry
☐ Yes ☐ No	Heart valve prosthesis	☐ Yes ☐ No	Breathing problems or motion disorder
☐ Yes ☐ No	Artificial or prosthetic limb	☐ Yes ☐ No	Dental/Medical care done outside of U.S.A.

☐ Yes ☐ No Other implant: _____

☐ Yes ☐ No Previous surgeries (if yes, please list): _____

_____

For Female Patients: Date of last menstrual period _____/_____/_____ Post Menopausal? ☐ Yes ☐ No

Are you pregnant or experiencing a late menstrual period? ☐ Yes ☐ No

Are you currently breast feeding? ☐ Yes ☐ No

Intrauterine device (IUD)? ☐ Yes ☐ No

I attest that the above information is correct to the best of my knowledge. I have read and understand the contents of this form and have been given the opportunity to ask questions regarding the above information and the MRI procedure.

Signature of Person Completing Form: _____ Date: _____/_____/_____

Form Completed by: ☐ Patient ☐ Parent ☐ Guardian _____