



Hoffman Estates MRI

Date ____/____/____

Last Name _____ First Name _____ MI _____

Address _____ City _____ State _____ Zip _____

Date of Birth ____/____/____ Male Female Height _____' _____" Weight _____

MRI will contact you to schedule your appointment, please list your contact number:

(circle one) Home / Cell / Work: (_____) _____ Ordering Physician _____

Primary Care Physician: _____ Phone: (_____) _____

- 1. Have you had prior surgery or an operation of any kind? Yes No
- 2. If you answered Yes, please list them below.

Date ____/____/____ Type Of Surgery _____

Date ____/____/____ Type Of Surgery _____

Date ____/____/____ Type Of Surgery _____

Date ____/____/____ Type Of Surgery _____

- 3. Have you experienced any problems related to a previous MRI examination or MRI procedure? Yes No
- 4. Do you work with or grind metal? Yes No
- 5. Have you ever had an injury involving a metallic object or fragment (e.g., metallic slivers, shaving, foreign body, etc)? Yes No
- 6. Are you allergic to any medications? Yes No
If yes, please list: _____
- 7. Do you have a history of asthma, allergic reactions, respiratory disease, or reaction to a contrast medium or dye used for an MRI, CT, or X-ray examination? Yes No
- 8. Do you have anemia or any disease(s) that affects your blood, a history of renal (kidney) disease, renal (kidney) failure, renal (kidney) transplant, high blood pressure (hypertension), liver (hepatic) disease, a history of diabetes, or seizures? Yes No
If yes, please describe: _____

For female patients

- 9. Date of last menstrual period: ____/____/____ Post Menopausal? Yes No
- 10. Are you pregnant or experiencing a late menstrual period? Yes No
- 11. Are you taking oral contraceptives or receiving hormonal treatment? Yes No
- 12. Are you taking any type of fertility medication or having fertility treatments? Yes No
If yes, please describe: _____
- 13. Are you currently breastfeeding? Yes No

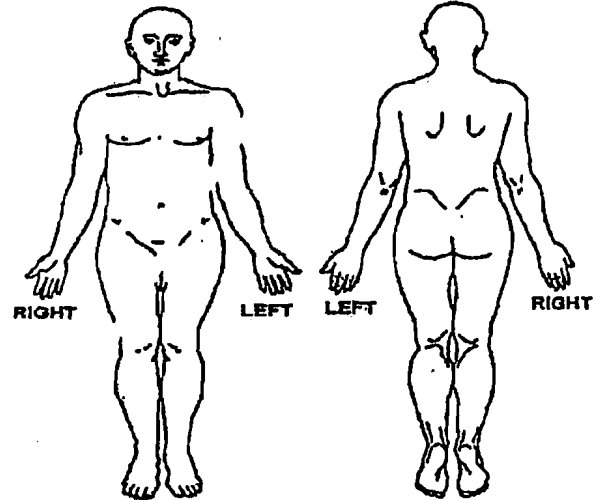


Warning: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure (i.e., MRI, MR angiography, functional MRI, MR spectroscopy). Do not enter the MR system room or MR environment if you have any questions or concern regarding an implant, device, or object. Consult the MRI Technologist or Radiologist BEFORE entering the MR system room. The MR system magnet is ALWAYS on.

Please indicate if you have any of the following:

- Yes No Aneurysm clip(s)
- Yes No Cardiac pacemaker
- Yes No Implanted cardioverter defibrillator (ICD)
- Yes No Electronic implant or device
- Yes No Magnetically-activated implant or device
- Yes No Neurostimulation system
- Yes No Spinal cord stimulator
- Yes No Internal electrodes or wires
- Yes No Bone growth/bone stimulator
- Yes No Cochlear, otologic, or other ear implant
- Yes No Insulin or other infusion pump
- Yes No Implanted drug infusion device
- Yes No Any type of prosthesis (eye, penile, etc.)
- Yes No Heart valve prosthesis
- Yes No Eyelid spring or wire
- Yes No Artificial or prosthetic limb
- Yes No Metal stent, filter, or coil
- Yes No Shunt (spinal or intraventricular)
- Yes No Vascular access port and/or catheter
- Yes No Radiation seeds or other implants
- Yes No Medication patch (Nicotine, Nitroglycerine)
- Yes No Any metallic fragment or foreign body
- Yes No Wire mesh implant
- Yes No Tissue expander (e.g., breast)
- Yes No Surgical staples, clips, or metallic sutures
- Yes No Joint replacement (hip, knee, etc.)
- Yes No Bone/joint pin, screw, nail, wire, plate, etc.
- Yes No IUD, diaphragm, or pessary
- Yes No Tattoo or permanent makeup
- Yes No Body piercing jewelry
- Yes No Hearing aid
(remove before entering MR system room)
- Yes No Breathing problem or motion disorder
- Yes No Claustrophobia

Please mark on the figure(s) below the location of any implant or metal inside of your body.



IMPORTANT INSTRUCTIONS

Before entering the MR environment or MR system room, you must remove all metallic objects including hearing aids, dentures, partial plates, keys, beeper, cell phone, eyeglasses, hair pins, batteries, jewelry, body piercing jewelry, watch, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools, clothing with metal fasteners & clothing with metallic threads.

Please consult the MRI Technologist or Radiologist if you have any questions or concern BEFORE you enter the MR system room.

NOTE: You may be advised or required to wear earplugs or other hearing protection during the MR procedure to prevent possible problems or hazards related to acoustic noise.

I attest that the above information is correct to the best of my knowledge. I read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and regarding the MR procedure that I am about to undergo.

Signature of Person Completing Form: _____
Signature

Date ____/____/____

Form Completed By: Patient Relative Nurse _____
Print name Relationship to patient

Form Information Reviewed By: _____
Print name Signature

MRI Technologist Nurse Radiologist Other _____