

Advancing Medical Imaging Since 1916

MRI PATIENT CHECKLIST

Name: _____

Date: _____

Referring Physician: _____

Weight: _____

**IT IS VERY IMPORTANT TO REMOVE AND STORE ALL JEWELRY
SAFELY WHILE WAITING FOR MRI.**

DO YOU HAVE OR HAVE YOU EVER HAD:

	<u>Yes</u>	<u>No</u>	<u>Unsure</u>
Pacemaker/implanted defibrillator	_____	_____	_____
Artificial heart valve/stent/filter	_____	_____	_____
Cranial (head) surgery	_____	_____	_____
Aneurysm repair or vascular clips	_____	_____	_____
Implanted insulin or medication pump/neuros stimulator	_____	_____	_____
Eye, ear, or penile implants	_____	_____	_____
Artificial joints and/or limbs	_____	_____	_____
Metallic foreign object (example: metal splinter or shrapnel)	_____	_____	_____
Body piercing/tattoos	_____	_____	_____
Have you ever done welding or sheet metal work?	_____	_____	_____
History of kidney disease?	_____	_____	_____

**If unsure, the technologist will consult with a radiologist who may obtain
an x-ray of the body part in question.**

Do you presently have breast tissue expander?
If yes which type? _____

Yes No

ARE YOU WEARING ANY OF THE FOLLOWING:

Removable dental work	_____	_____
Hearing aid	_____	_____
Eye make-up or permanent eyeliner	_____	_____
IUD/copper	_____	_____
Transdermal patch (what type) _____	_____	_____

Patient signature: _____

Technologist: _____

DOCTORS GROOVER
CHRISTIE & MERRITT
RADIOLOGISTS

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What are your present complaints/symptoms? Why did your doctor send you for an MRI?

Do these complaints result from an injury? Yes ___ No ___

Date of injury: _____

Nature of injury: _____

Have you every had an MRI scan before? Yes ___ No ___

Location and date of previous MRI scans: _____

Have you had any other diagnostic studies for your present condition? Yes ___ No ___

Exam type: _____ What were the results? _____

Have you had any previous surgery on this part of your body? Yes ___ No ___

If yes, what type? _____ Date of surgery: _____

Do you have, or have you had, any type of cancer? Yes ___ No ___

If yes, what type of cancer have you had? _____

Have you ever had any radiation therapy or chemotherapy? Yes ___ No ___

Please explain if there is anything else about your condition that you would like the radiologist to know:

Patient signature: _____ Technologist: _____