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 an allergic 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: _____

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.

_____ _____

PARENT/ GUARDIAN SIGNATURE **DATE**

_____ _____ **FINAL STOP CHECK INTIALS:**_____

TECHNOLOGIST SIGNATURE **DATE**