Advanced Open Imaging
Imaging & Vein Centers of Idaho

Patient Name:_____ **DOB**_____
MR#:_____
Music Station #_____
Exam:_____ **DOS:**_____
Symptoms: _____
_____

DO YOU WEIGH AN EXCESS OF 350 LBS? __ Yes ↘↘No **Height:** _____ **Weight:** _____ **YES NO** ☐ **ARE YOU CLAUSTROPHOBIC? IF SO ANSWER THE FOLLOWING** ***DID YOU SELF MEDICATE?***_____ ***TYPE OF MEDICATION*:** _____	**SURGERY (of body part we are Scanning):** **DATE:**_____ **FACILITY:**_____ **Please notify the center *IMMEDIATLY* if any of the following apply:** **___Pacemaker ___Aneurysm Clips ___Shrapnel ___Stents** **___Incident of Metal in the eye(s)**
Has there ever been a problem with medical staff starting an IV or drawing blood?_____	

Please list all surgeries or operations you have had in your lifetime.

Date: _____ **Surgery:** _____

Date: _____ **Surgery:** _____

Date: _____ **Surgery:** _____

Date: _____ **Surgery:** _____

Date: _____ **Surgery:** _____

List any known Allergies:_____

_____

Have you ever had an IMAGING study of the SAME BODY PART we are examining today? NO_____ YES_____

IF YES PLEASE LIST: **Date** **Facility**

MRI _____

CT _____

US _____

XRAY _____

OTHER _____

WARNING: Certain implants, devices or objects may be hazardous to you and/or may interfere with the MRI procedure. **DO NOT ENTER** the MRI system room or MRI environment if you have any questions or concern regarding an implant device or object. Consult the MRI Technologist or Radiologist **BEFORE** entering the MRI system room. **THE MRI MAGNET IS ALWAYS ON.**

YES NO

- **HAVE YOU EVER HAD AN INJURY TO THE EYE INVOLVING A METALLIC OBJECT OR FRAGMENT?**
- **ARE YOU CURRENTLY IN RENAL FAILURE OR ON DIALYSIS, HAVE KIDNEY PROBLEMS OR RENAL INSUFFICIENCY?**
- **ARE YOU DIABETIC?**
- **DO YOU OR HAVE YOU HAD A CARDIAC PACEMAKER?**
- **DO YOU HAVE AN IMPLANTED CARDIAC DEFIBRILLATOR?**
- **DO YOU HAVE AN IMPLANTED BIO STIMULATOR OR TENS UNIT?**
- **DO YOU HAVE OR HAVE YOU HAD A COCHLEAR (INNER EAR) IMPLANT?**

PLEASE INDICATE IF YOU NOW HAVE OR HAVE EVER HAD ANY OF THE FOLLOWING:

YES NO

- **SWAN-GANZ OR THERMODILUTION CATHETER**
- **ELECTRONIC IMPLANT/DEVICE**
- **MAGNETIC IMPLANT DEVICE**
- **IMPLANTED DRUG INFUSION DEVICE**
- **NEUROSTIMULATION SYSTEM**
- **INTERNAL ELECTRODES/WIRES**
- **BONE GROWTH/FUSION STIMULATOR**
- **TEMPERATURE FOLEY**
- **INSULIN/INFUSION PUMP**
- **ARTIFICIAL/PROSTHETIC LIMB**
- **EYELID SPRING/WIRE**
- **HEART VALVE PROSTHESIS**
- **PROSTHESIS (ANY TYPE)**
- **EAR IMPLANT TYPE: _____**
- **OTHER IMPLANT: _____**

YES NO

- **CANCER: TYPE/DATE: _____**
- **RADIATION SEEDS OR IMPLANTS**
- **STENT/FILTER/COIL: LOCATION _____**
- **SPINAL/INTERVENTRICULAR SHUNT**
- **VASCULAR ACCESS PORT/CATHETER**
- **TISSUE EXPANDER (E.G. BREAST)**
- **SURGICAL STAPLES/CLIPS/SUTURES**
- **JOINT REPLACEMENT (HIP/KNEE/ETC.)**
- **BONE OR JOINT PIN/SCREW/NAIL/PLATE**
- **ANY METALLIC FRAGMENT/FOREIGN BODY**
- **DENTURES OR PARTIAL PLATES**
- **HEARING AID (MUST REMOVE)**
- **MEDICATION PATCH (NICOTINE, NITROGLYCERINE, ETC.)**
- **TATTOOS OR PERMANENT MAKEUP**
- **BODY PIERCING JEWELRY**

FOR FEMALE PATIENTS

YES NO

- **ARE YOU PREGNANT OR EXPERIENCING A LATE MENSTRUAL PERIOD? DATE OF LAST PERIOD: _____**
- **ARE YOU POSTMENOPAUSAL?**
- **ARE YOU CURRENTLY USING AN IUD, DIAPHRAGM OR PESSARY?**
- **ARE YOU TAKING ORAL CONTRACEPTIVES OR RECEIVING HORMONAL TREATMENT? _____**
- **ARE YOU CURRENTLY BREAST FEEDING**

- **Please consult the MRI Technologist or Radiologist if you have any questions or concerns BEFORE you enter the MRI system room.**
- **The MRI procedure you have been scheduled for may require the intravenous injection of a non-iodinated contrast solution. It is used to enhance the ability of MRI to facilitate diagnosis. While there are no known contraindications, mild side effects including nausea or slight headaches may occur. This solution is not the same used for CT scans or angiography**
- **I attest that the above information is correct to the best of my knowledge. I have read and understand the entire contents of this form and I have had the opportunity to ask questions regarding the information on this form.**

SIGNATURE OF PERSON COMPLETING FORM: _____

RELATIONSHIP: _____ DATE: _____