Patient Name:

KRC
KENOSHA RADIOLOGY CENTER

MRI PATIENT INFORMATION SURVEY

AREA TO BE SCANNED:_____ Patient's Height_____Patient's Weight_____

1) Please describe your symptoms: _____

_____

2) Have you had any previous diagnostic testing for this condition? (location/date/exam)

_____

3) Have you ***EVER*** had any surgery or other invasive procedure? Yes ☐ No ☐

If yes, please list: _____

_____

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

5) Are you breastfeeding? Yes ☐ No ☐

6) Are you currently taking or have you recently taken any medication? Yes ☐ No ☐

If yes, please list: _____

7) Do you have any drug allergies? Yes ☐ No ☐

If yes, please list: _____

8) Do you have anemia or any disease that affect your blood, a history of renal disease or seizures? Yes ☐ No ☐

9) Have you ever had asthma, allergic reaction, respiratory disease, or other reaction to a contrast medium or dye used for an MRI or CT exam? Yes ☐ No ☐

If yes, please describe: _____

10) Have you ever worked with metal(cutting/grinding, ect.) or ever had an injury to your eyes involving a metal object (e.g. metallic slivers, shavings, BB's, or any foreign body)? Yes ☐ No ☐

11) Did you **ALWAYS** wear eye protection? Yes ☐ No ☐

12) Have you ever had a penetrating injury with metal such as shrapnel, knife or gunshot wound? Yes ☐ No ☐

_____

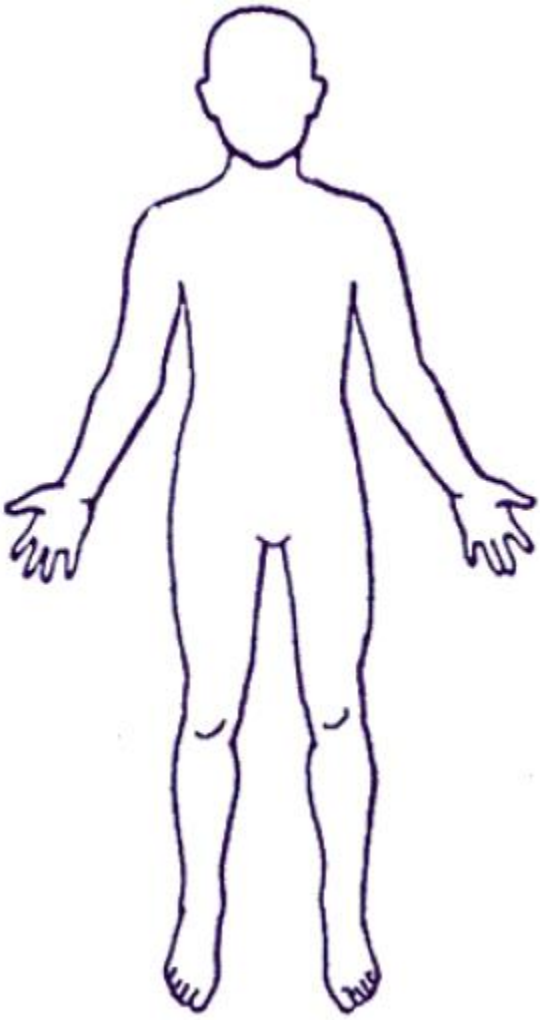
****If there is any possibility that you may have metal particles in your eyes an x-ray will be required before the MRI scan is performed.**

Patient Name:

Some of the following items may be hazardous to your safety and some can interfere with the MRI examination. Please check the correct answer for each of the following:

☐ Yes	☐ No	Cardiac pacemaker
☐ Yes	☐ No	Implanted cardiac defibrillator
☐ Yes	☐ No	Aneurysm clips(s)
☐ Yes	☐ No	Carotid artery vascular clamp
☐ Yes	☐ No	Neurostimulator
☐ Yes	☐ No	Insulin or infusion pump
☐ Yes	☐ No	Implanted drug infusion device
☐ Yes	☐ No	Bone growth/fusion stimulator
☐ Yes	☐ No	Cochlear, otologic, or ear implant
☐ Yes	☐ No	Any type of prosthesis (eye, penile, etc.)
☐ Yes	☐ No	Heart valve prosthesis
☐ Yes	☐ No	Artificial limb or joint
☐ Yes	☐ No	Electrodes (on body, head, or brain)
☐ Yes	☐ No	Intravascular stents, filters, or coils
☐ Yes	☐ No	Shunt (spinal or intraventricular)
☐ Yes	☐ No	Vascular access port and/or catheter
☐ Yes	☐ No	Swan-Ganz catheter
☐ Yes	☐ No	Any implant held in place by a magnet
☐ Yes	☐ No	Transdermal delivery system (Nitro)
☐ Yes	☐ No	IUD or diaphragm
☐ Yes	☐ No	Tattooed makeup (eyeliner, lips, etc.)
☐ Yes	☐ No	Body piercing(s)
☐ Yes	☐ No	Any metal fragments
☐ Yes	☐ No	Internal pacing wires
☐ Yes	☐ No	Aortic clip
☐ Yes	☐ No	Metal or wire mesh implants
☐ Yes	☐ No	Wire sutures or surgical staples
☐ Yes	☐ No	Harrington rods (spine)
☐ Yes	☐ No	Metal rods in bones
☐ Yes	☐ No	Joint replacement _____
☐ Yes	☐ No	Bone/joint pin, screw, nail, wire, plate
☐ Yes	☐ No	Hearing aid (***Remove before MRI)***
☐ Yes	☐ No	Dentures ***(Remove before MRI)***
☐ Yes	☐ No	Breathing disorder
☐ Yes	☐ No	Motion disorder
☐ Yes	☐ No	Claustrophobia
☐ Yes	☐ No	Anxiety

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



*Before your **MRI,** please remove all metallic objects including keys, hair pins, barrettes, jewelry, watch, safety pins, paperclips, money clips, credit cards, coins, pens, belt, metal buttons, pocket knife, & clothing with metal in the material*

Other Please Explain: _____

NOTE: YOU ARE REQUIRED TO WEAR EAR PLUGS OR EARPHONES DURING THE MRI EXAMINATION.

ACKNOWLEDGEMENT:

I have read and understand the Patient Information Survey and agree to be imaged.

_____

Patient's Signature: _____ Date _____

Reviewer's Signature: _____