MRI Patient History Form

MRI Exam: _______________
Weight:_____HT:________
Age:_____

Please tell us in detail why you are having this MRI Today(What is your problem? What part of the body and how long you have had this problem.)

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Was there any injury that is related to this problem? Yes or No
If Yes, Date of the injury? ____________

List Any Known Drug Allergies:

____

List Any Medications:

____

List Any Surgery to the area that is being Scanned & Dates Done:

____

Ever have metal removed from your eyes by a doctor?__________

Ever have Kidney or Liver Problems? __________________

____

This Area for Staff Use:

Contrast Info:
Amount:__________ Type:________ Lot#:_________ Exp. Date:________
Site of Injection:_________ Hand or Power Injected
Any Problems____

Lab Info:
Creat:_________ GFR:_______ CO2:_______

Technologist Signature: _________________________________ Date: ____________