MAGNETIC RESONANCE IMAGING (MRI)-PATIENT HISTORY

Back Bay Imaging
301 Bayview Circle, Suite 105
Newport Beach, CA 92660
ph (949) 799-3000
fax (949) 799-4000

Patient Name _____

DOB _____ **Weight** _____ **lbs** **Height** ____'____"

Referring Physician _____ **WI#** _____

Procedure _____ **Date of Exam** _____

When is your next visit with the doctor ordering the exam? _____

1. **Is this exam due to an injury?** ☐ Yes / ☐ No ☐ Right / ☐ Left When? _____
2. **Have you had a surgery on the area that is being imaged?** ☐ Yes / ☐ No
   If so, what type & when?_____
3. **Do you have any metal clips, pins, staples, etc., in your body from a previous surgery?** ☐ Yes / ☐ No
4. **If female, are you pregnant?** ☐ Yes / ☐ No When was your last menstrual period? _____
5. **Have you worked in a metal shop, or have had metal in your eyes?** ☐ Yes / ☐ No
6. **Have you had (check) a:** ☐ MRI / ☐ CT / ☐ VASCULAR US of this area? When?_____Where? _____
7. **Do you have a history of cancer?** ☐ Yes / ☐ No What type? _____When? _____
8. **Do you wear a medication patch such as: ANDRODERM, TRANSDERM-NITRO (Nitroglycerin Patch), HABITROL, NICODERM, TRANSDERM SCOP, CATAPRES-TTS, or any other?** Please inform the staff, as it requires removal for the duration of the exam. ☐ Yes / ☐ No

PLEASE INDICATE IF YOU HAVE ANY OF THE FOLLOWING:

Yes	No		Yes	No		Yes	No	
___	___	Cardiac pacemaker	___	___	Aneurysm clip(s)	___	___	Ear implant
___	___	Orbital/eye prosthesis	___	___	Internal shunt	___	___	Penile prosthesis
___	___	Removable dental work	___	___	Wire sutures	___	___	Artificial limb/joint
___	___	Any metallic foreign body	___	___	Dental braces	___	___	Internal electrode
___	___	Surgical clip or staple	___	___	Vascular clip(s)	___	___	IUD
___	___	Electronic, mechanical or magnetic implant	___	___	Any implanted items _____			

___ ___ Prosthetic Heart Valve (Pre 6000 Starr-Edwards caged-ball prosthesis, available from 1960-64 is contraindicated for MRI.)

I attest that the above information is correct to the best of my knowledge. I have read and understand the above contents of this form and have had the opportunity to ask questions regarding information on this form.

PATIENT SIGNATURE: _____ **DATE:** _____

TECHNOLOGIST SECTION: (OFFICE USE ONLY)

1. Has technologist verified above items? ____ Yes
2. Reason for exam – chief complaint, symptoms, abnormal lab results, etc. _____
_____
3. Routine Sequence ____Yes ____No Additional Sequences_____
4. Sedation ____Yes ____No If yes, medication and dosage: _____
5. Contrast ____Yes ____No If yes, type & amount_____
6. Patient tolerated IV contrast injection?___Yes ____No (If no attach explanation)
7. Technologist comments: _____
8. Technologist: _____