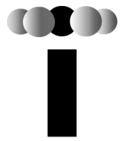

TOWER
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IMAGING
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MRI EXAM

MRI EXAM

Date ________ / ________ / _________ Patient ID#: ___________________________________

Name: ____

Sex: ___________ Age:_____________ Physician: _____________________________________

Date of Birth: ________ / ________ / ________ Height: ______________ Weight: ________________

Procedure: ____

Diagnosis: ____

Reason for Exam: ____

____

____

____

Have you had a previous MRI? ( ) Yes ( ) No If yes, what body part? _______________________

The following items may interfere with MRI imaging, and some could be hazardous to your safety.
Please check the following:

Cardiac Pacemaker	( ) No	( ) Yes
Cochlear Implants	( ) No	( ) Yes
Brain Surgery	( ) No	( ) Yes
Seizures	( ) No	( ) Yes
Neurostimulator (TENS unit)	( ) No	( ) Yes
Insulin Pump	( ) No	( ) Yes
Hearing Aid	( ) No	( ) Yes
IUD	( ) No	( ) Yes
Females: Is there a possibility you may be pregnant?	( ) No	( ) Yes
Fractured Bones, treated w/metal rods, screws	( ) No	( ) Yes
Spinal Rods	( ) No	( ) Yes
Prosthesis	( ) No	( ) Yes
Wire Suture	( ) No	( ) Yes
Shrapnel, Bullets	( ) No	( ) Yes
Removable Dentures	( ) No	( ) Yes
Any Metal Fragments	( ) No	( ) Yes
Have you ever worked w/ grinding metal	( ) No	( ) Yes
Other metal implants	( ) No	( ) Yes
Penile Prosthesis	( ) No	( ) Yes
Orbital/Eye Prosthesis	( ) No	( ) Yes
Artificial Limb or Joint	( ) No	( ) Yes
Dental Retainer	( ) No	( ) Yes
Metal Implants, Devices, Pumps, Etc.	( ) No	( ) Yes

Continued…

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MRI EXAM

For female patients:

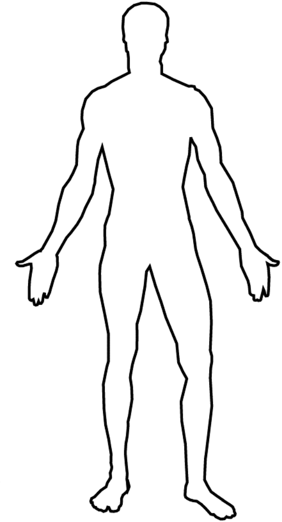
Are you breast feeding	( ) No	( ) Yes

Questions Related to Your MRI Exam: (Please check all that apply)

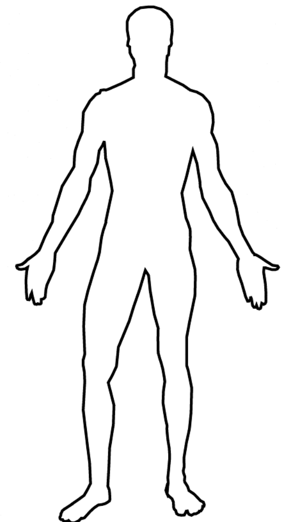
Brain Surgery	( ) No	( ) Yes
Radiation Therapy	( ) No	( ) Yes
Chemotherapy	( ) No	( ) Yes
History of Cancer	( ) No	( ) Yes
Headaches	( ) No	( ) Yes
Seizures	( ) No	( ) Yes
Memory Loss	( ) No	( ) Yes
Hearing Problems	( ) No	( ) Yes
Paralysis	( ) No	( ) Yes
Dizziness	( ) No	( ) Yes
Numbness	( ) No	( ) Yes
Been Knocked Unconscious	( ) No	( ) Yes
TMJ (Jaw) Problems	( ) No	( ) Yes
Blurry Vision	( ) No	( ) Yes
Neck Pain	( ) No	( ) Yes
Upper Extremity Pain	( ) No	( ) Yes
Lower Extremity Pain	( ) No	( ) Yes
Chest Surgery	( ) No	( ) Yes
Abdominal Surgery	( ) No	( ) Yes
Weight Gain / Loss	( ) No	( ) Yes
Vomiting	( ) No	( ) Yes
Diarrhea	( ) No	( ) Yes
Chest Pain	( ) No	( ) Yes
Abdominal Pain	( ) No	( ) Yes
Surgery on body part to be examined	( ) No	( ) Yes
Pain	( ) No	( ) Yes
Popping of Joint	( ) No	( ) Yes
Clicking of Joint	( ) No	( ) Yes

Please indicate location of pain on diagram:

FRONT



BACK



If you answered yes to any of the above questions, please explain:

____

____

____

____

Other patient symptoms:

____

Patient's Signature: ____________________________________ Date: _______ / _______ / _______

Technologist: ____