CLARKSVILLE
IMAGING
CENTER
OPEN MRI • CT • ULTRASOUND

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MAGNETIC RESONANCE IMAGING
PATIENT INFORMATION FORM

Name ____________________

Birth Date ____________________

Telephone # ____________________

Physician ____________________

Exam Ordered ____________________

Reason for Examination ____________________

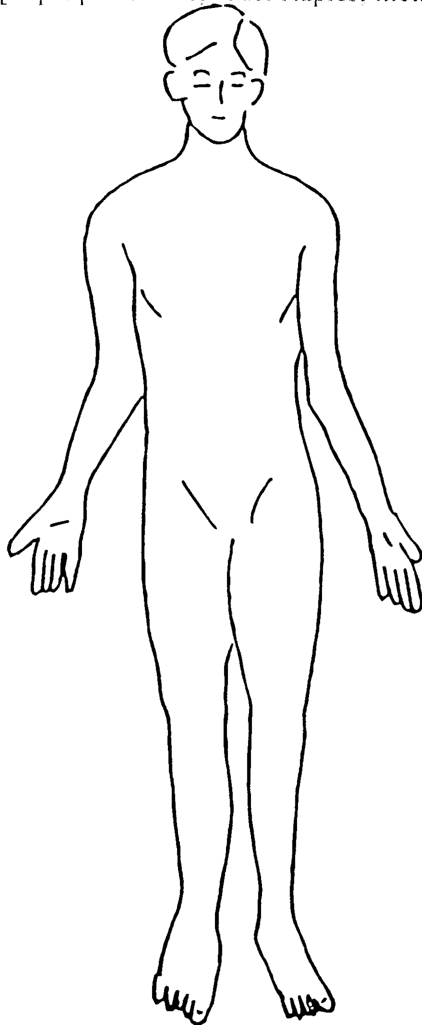
Weight ____________________

Previous MRI or CT __________ Date __________

Facility Where Study Performed ____________________

PATIENT SCREENING & HISTORY

Please note on the drawing the location of any metal inside your body. [clips, pins, nails, rods, staples, metal implants]



The following questions must be answered before the exam is performed:

_____ Do you have a cardiac pacemaker?

_____ Have you ever had chest or heart surgery?

_____ Do you have Stents or Filters anywhere in your body?

_____ Have you ever had brain surgery?

_____ Do you have an aneurysm clip in your brain?

_____ Do you have an inner ear implant?

_____ Do you have a neural stimulator implant?

_____ Do you have any other implanted devices in your body?
If yes, please explain: ____________________

_____ Have you ever had any metal in your eyes?

_____ Are you pregnant?

_____ Are you breastfeeding?

_____ Have you had any surgery in the last six weeks?

_____ Have you ever had back surgery?

_____ History of cancer or tumor?

_____ Claustrophobia (fear of closed spaces)

_____ Have you ever had a liver transplant?

_____ Are you a diabetic?

_____ Do you have a history of Renal (kidney) disease or only have one kidney?

_____ Do you have a personal history of renal (kidney) failure?

Do you fully understand the questions that you have answered? __________

Patient Signature ____________________ Date __________

Witness ____________________ Date __________