Place Patient Label Here

MRI Patient History

Oregon Medical Group Imaging
920 Country Club Rd, Suite 100A
Eugene, OR 97401
(541) 242-4162 • Fax (541) 345-2385

Patient Name _____

DOB _____ Weight _____ Scan Date _____

Primary Care Physician _____

1. Reason for this exam? (e.g. headaches, low back pain, right arm pain, injury) _____

_____

2. Do you have:

Yes	No		Yes	No	
☐	☐	Cardiac pacemaker	☐	☐	Heart valve
☐	☐	At risk for metal fragments in eyes	☐	☐	Neurostimulator
☐	☐	Brain surgery / aneurysm clip	☐	☐	Pregnancy
☐	☐	Implanted cardiac defibrillator	☐	☐	Hearing aids
☐	☐	Swan Ganz catheter	☐	☐	Nitroglycerin patch
☐	☐	Implanted electronic devices	☐	☐	Orbital prosthesis
☐	☐	Shunt	☐	☐	Shrapnel
☐	☐	Metallic implants or prosthesis	☐	☐	Heart surgery
☐	☐	Removable dental work	☐	☐	Vascular clips or stents
☐	☐	Dental bridges or braces	☐	☐	Insulin or Infusion pump
☐	☐	Metal worker history	☐	☐	Claustrophobic
☐	☐	Middle ear prosthesis			

3. Have you had a prior exam, in the area of concern? ☐ Yes ☐ No

When?	Where was it done?	What kind? (CT, MRI, Myelogram, etc)
_____	_____	_____
_____	_____	_____

4. Have you ever had any surgery in the area of concern? ☐ Yes ☐ No

When & Where?	Location/Level	Reason?
_____	_____	_____
_____	_____	_____

5. By signing below, you acknowledge that you have read and understand this questionnaire.

_____ SIGNATURE _____ DATE

IMPORTANT:

If you are taking tranquilizing medication, someone must drive you to & from your MRI appointment.

DO NOT WRITE IN SHADED AREA

Tech notes _____

IV Contrast _____ cc of _____

Radiologist