

MRI
Valley Imaging Center

Please Print

Patient ID #: _____

Exam _____

Date: _____ Ordering Physician: _____

Office #: _____

Name: _____ Age: ____ Sex: Male Female

DOB: _____ Weight: _____ Height: _____

Home Phone #: _____

Why did your doctor send you for an MRI? What are your symptoms? _____

Do you have any of the following?	Please Circle		Please Circle	
Cardiac Pacemaker	YES	NO	Aneurysm clip	YES NO
Aneurysm clip	YES	NO	Hearing Aid	YES NO
Bone Growth Stimulator	YES	NO	Metal in Eye	YES NO
Cochlear (Ear) Implant	YES	NO	Penal Prosthesis	YES NO
Heart Valve prosthesis	YES	NO	Tattooed Eyeliner	YES NO
Orbital Eye Prosthesis (Artificial Eye)	YES	NO	Pain Pump	YES NO
Shrapnel or Bullet	YES	NO		
Any Dental Item held in place by a magnet	YES	NO	Kidney Disease	YES NO
Any type of Removable Dental item	YES	NO	Liver Disease	YES NO
Diaphragm or IUD	YES	NO	Diabetes	YES NO
Artificial Limb or Joint	YES	NO	On Dialysis	YES NO
Transdermal Patch (Nicotine, Birth control)	YES	NO	Heart Disease	YES NO

Have you ever had a surgical procedure or operation related to the body part being studied by MRI? If yes, when? _____

If you are having a spine scan:

Where is your pain? _____

Does the pain go down your arm? YES/NO If yes, which one? RIGHT/LEFT

Does the pain go down your leg? YES/NO If yes, which one? RIGHT/LEFT

Are you pregnant? YES NO

Have you ever had an MRI before? YES NO

If yes, what facility? _____

Have you ever had a CT before? If yes, where/when: _____

Have you ever had cancer? If yes, what area of the body? _____

Patient Signature: _____

For Office Use Only

IMPRESSION: _____

Meds.: _____ mg Orally _____ mg I.V.

GFR _____ BUN _____ CREATININE _____

Type of Contrast _____ Amount _____ Route _____

Technologist: _____