THE MRI CENTER
www.TheMRICenterMS.com
Fax: 228-396-3550

Cedar Lake Office
Phone: 228-354-0251

East Lake Office
Phone: 228-447-4MRI (4674)

Name: _____

DOB: ___ /___ /_____ MRN: _____

Weight: _____ Sex: M / F

Exam Date: ____ / ____/ _____

I am having a MRI of: _____ Referring Clinician: _____

Reason for Exam:

Was this related to an injury at work? YES NO

Was this related to an automobile accident? YES NO

Type of injury or trauma: _____

If injury or trauma, date if occurred:_____

Please check all that apply:

- Weakness/ Instability/ "Giving Way"
- Clicking/ popping/ locking
- Loss of motion
- Numbness/ tingling
- Swelling/ bruising
- Skin redness/ wound
- History of dislocation/ fracture
- Cyst/ mass/ lump
- Previous injections/ aspirations?
  - If so, when?_____
- Previous Arthroscopy or Surgery on this area being scanned today?
  - If so, when?_____

All Surgical History:

_____

_____

_____

_____

Additional History / Other Symptoms:

_____

_____

_____

_____

_____

Have you ever been injured by a metallic foreign body? (Bullets/ BB/ Shrapnel, Etc)? YES NO

Have you ever had an eye injury involving metal slivers or shavings? YES NO

If yes, was the metal removed? YES NO

Please check all that apply. Do you have any of the following?

- Pacemaker/ Defibrillator
- Cochlear Implant/ Metal Ear Implant
- Aneurysm/ Brain Clips / Coil
- Aortic Clips
- Heart Valve
- Stents
- Shunt
- Pain Pump
- Insulin Pump
- Metal Rods/ Screws/ Pins/ Plates
- Harrington Rods
- Joint Replacements
- Hearing Aids
- IUD
- Dental Implants
- Body Piercing/ Tattoos/ Tattoo Makeup
- Other Implants:_____
- Claustrophobia
- Asthma
- Sickle Cell Anemia
- Cardiovascular Disease
- Multiple Sclerosis
- Kidney Disease
- Hypertension
- Dialysis
- Diabetes
- Liver Disease
- Respiratory Disorders
- Multiple Myeloma
- Diuretic Medications Taken
- Organ Transplant
- Currently Taking Chemo / Radiation
- Cancer

THE MRI CENTER
www.TheMRICenterMS.com
Fax: 228-396-3550

Cedar Lake Office
Phone: 228-354-0251

East Lake Office
Phone: 228-447-4MRI (4674)

Name: _____

DOB: ___ /___ /_____ MRN: _____

Exam Date: ___ / ___ / _____

Do you have history of Cancer? Please list what type, date diagnosed, and type of treatment received:

_____

Do you have any drug allergies? Please list them here:

_____

Are you wearing any kind of medication administered through the skin? YES NO

Have you ever had a X-ray, CT, MRI, US done on this area being scanned today? YES NO

If yes, when and where? _____

For Women Only:

When was the first day of your last menstrual cycle? _____

Are you pregnant? YES NO

Are you using birth control? YES NO

Are you breastfeeding? YES NO

Are you post-menopausal? YES NO

Are you receiving hormone replacement therapy? YES NO

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

****PLEASE REMOVE ALL JEWELRY, WATCHES, KEYS, CELL PHONES, HAIR PINS, HAIR PIECES, POCKET KNIVES, BELTS, ETC.****

****PLEASE MAKE SURE ALL OF YOUR POCKETS ARE COMPLETELY EMPTY.****

The MRI Center is NOT responsible for any personal belongings. Thank you.

PLEASE INFORM OUR STAFF IF YOU HAVE TAKEN ANY MEDICATION (FOR CLAUSTROPHOBIA) PRIOR TO YOUR EXAM.

Patient / Guardian Signature: _____ Date: ___ / ___/ ____

STAFF ONLY:

Labs:

GFR _____

BUN /Creatinine____/_____

Draw Date____/____/_____

IV:

Started By _____

# of Attempts_____

Location_____

Contrast:

Type_____ Dosage _____CC

Lot #_____ Exp._____

Time of Injection _____

Radiologist on Site _____

Tech Comments: _____

_____

_____

Patient Interviewed By: _____ Technologist Performing Scan: _____ Date: ____/____/____