DOCTORS GROOVER CHRISTIE & MERRITT
RADIOLOGISTS

Advancing Medical Imaging Since 1916

MRI PATIENT CHECKLIST

Name: ______________________ Date: ______________________

Referring Physician: ______________________ Weight: ______________________

IT IS VERY IMPORTANT TO REMOVE AND STORE ALL JEWELRY SAFELY WHILE WAITING FOR MRI.

DO YOU HAVE OR HAVE YOU EVER HAD:	**Yes**	**No**	**Unsure**
Pacemaker/implanted defibrillator	____	___	______
Artificial heart valve/stent/filter	____	___	______
Cranial (head) surgery	____	___	______
Aneurysm repair or vascular clips	____	___	______
Implanted insulin or medication pump/neuros stimulator	____	___	______
Eye, ear, or penile implants	____	___	______
Artificial joints and/or limbs	____	___	______
Metallic foreign object (example: metal splinter or shrapnel) Body piercing/tattoos	____	___	______
Have you ever done welding or sheet metal work?	____	___	______
History of kidney disease?	____	___	______

If unsure, the technologist will consult with a radiologist who may obtain an x-ray of the body part in question.

Do you presently have breast tissue expander? Yes No
If yes which type? ______________________

ARE YOU WEARING ANY OF THE FOLLOWING:

Removable dental work	____	___
Hearing aid	____	___
Eye make-up or permanent eyeliner	____	___
IUD/copper	____	___
Transdermal patch (what type) ______________________	____	___

Patient signature: ______________________ Technologist: ______________________

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What are your present complaints/symptoms? Why did your doctor send you for an MRI?
____

____

Do these complaints result from an injury? Yes ___ No ___

Date of injury: ____

Nature of injury: ____

Have you every had an MRI scan before? Yes ___ No ___

Location and date of previous MRI scans: ____

Have you had any other diagnostic studies for your present condition? Yes ____ No ___

Exam type: ___________________ What were the results? ____________

____

Have you had any previous surgery on this part of your body? Yes __ No __

If yes, what type? _____________________ Date of surgery: _________________________

Do you have, or have you had, any type of cancer? Yes __ No ___

If yes, what type of cancer have you had? ____

Have you ever had any radiation therapy or chemotherapy? Yes __ No __

Please explain if there is anything else about your condition that you would like the radiologist to know:
____

Patient signature: _____________________________ Technologist: _______________