ROSEVILLE
DIAGNOSTIC IMAGING

TODAY'S DATE: _______________

NAME:______________________________ DATE OF BIRTH:______________________

WEIGHT:_____________HEIGHT:_________ ARE YOU PREGNANT? ❏YES ❏NO

HAVE YOU HAD AN MRI BEFORE?________➔➔**IF YES, WHEN AND WHERE?_____________

____

HAVE YOU HAD ANY SURGERY? ________➔➔**IF YES, WHEN AND WHAT KIND?__________

____

ARE YOU CURRENTLY OR HAVE YOU EVER WORKED AS A MACHINIST, METAL WORKER OR ANY PROFESSION GRINDING METAL?_______________________________________

THE FOLLOWING ITEMS MAY BE HAZARDOUS WITH MRI SCANNING. PLEASE CHECK THE APPROPRIATE COLUMN FOR EACH OF THE FOLLOWING:

YES	NO		YES	NO	
❏	❏	CARDIAC PACEMAKER	❏	❏	VENOUS "UMBRELLA"
❏	❏	INTRACRANIAL ANEURYSM CLIPS (BRAIN)	❏	❏	PROSTHESIS
❏	❏	WORKED IN METAL SHOP	❏	❏	IUD
❏	❏	KNOWN METAL FRAGMENTS IN OR AROUND EYES	❏	❏	SHRAPNEL OR BULLET
❏	❏	EAR IMPLANT	❏	❏	AORTIC CLIPS
❏	❏	INSULIN PUMP	❏	❏	HARRINGTON ROD
❏	❏	ELECTRODES	❏	❏	JOINT REPLACEMENT
❏	❏	NEUROSTIMULATOR (TENS UNIT)	❏	❏	HEARING AID
❏	❏	METAL IMPLANTS (IF YES, PLEASE EXPLAIN)	❏	❏	HEART VALVE
❏	❏	BONE OR JOINT PINS, SCREWS, WIRE SUTURES			
❏	❏	Have you had a Cough, Fever, or any Flu-like symptoms within the past 2 weeks?			
❏	❏	Have you recently come into contact with anyone who was COVID positive?			
❏	❏	Any recent travels outside of the USA			

What is your main complaint? ____
Is this a result of an injury? ❏YES ❏NO Type of injury: _______________When:___________
Do you have any other symptoms?____

Please remove all metallic objects before entering the MRI including jewelry, watch, hairpins. Please consult the MRI Technologist if you have questions or concerns BEFORE you enter the MR Suite.

I attest that the above information provided by me is correct to the best of my knowledge, I have read & understood the entire content of this form & I have had the opportunity to ask any unclear issue in this regard.

Patient's Signature: __________________________________Date:_______/_____/_____

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