Gulf Coast
MRI & Diagnostic
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MRI History Sheet

Date of Exam _____/_____/_____ Time of Exam _____ am/pm

Patient Name _____ D.O.B _____/_____/_____

Study _____

Technologist _____ Referring Physician _____

Type and Quantity of IV contrast: _____ Injection Site: _____

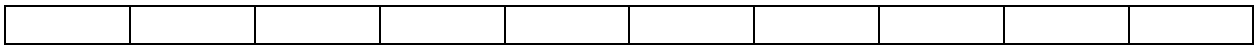
Lot # _____ Exp. Date ____/____/_____ Time of Injection _____ am/pm

Oral/ IV Sedation _____ Amount Given: _____ Creatnine _____eGFR_____

Pain? **Y** **N** If yes, where? _____

When did the pain occur? _____ How did the pain occur? _____

Rate pain from 0 to 10 with 0 indicating no pain and 10 representing the worst possible pain



0 1 2 3 4 5 6 7 8 9 10

No pain — Moderate pain — Worst pain

HIGH FIELD MRI ◯ **OPEN MRI** ◯

Numbness/Tingling ___YES ___NO
Aneurysm Clips ___YES ___NO
Diabetic ___YES ___NO
Electronic Implants ___YES ___NO
Claustrophobic ____YES ___NO
Asthma ____YES ___NO
Hay fever ____YES ___NO
Lung disease ____YES ___NO
Emphysema ____YES ___NO
Ulcer ____YES ___NO
Chest pain ____YES ___NO
Cough ____YES ___NO
COPD ____YES ___NO
Hives ____YES ___NO
Blurred vision ____YES ___NO

Arrhythmia ____YES ___NO
Aortic Stenosis___YES ___NO
CABG ____YES ___NO
Heart attack ____YES ___NO
Angina ____YES ___NO
Syncope ____YES ___NO
Hematuria ____YES ___NO
Blood in stool ____YES ___NO
Hernia ____YES ___NO
Weight loss ____YES ___NO
Constipation ____YES ___NO
Headaches ____YES ___NO
Diarrhea ____YES ___NO
Dizziness ____YES ___NO

Pulmonary Hyper ___YES __NO
Nausea ___YES ___NO
Vomiting ___YES ___NO
Shortness of Breath ___YES ___NO
Prev. Spinal Surgery ___YES ___NO
Allergic to Iodine ____YES ___NO
Cardiac Pacemaker ____YES ___NO
Shunts or Stents ____YES ___NO
Body Piercing ____YES ___NO
Prosthesis ____YES ___NO
Permanent Makeup ____YES ___NO
Heart Failure ____YES ___NO
Irregular Menstrual Cycle ___YES ___NO
Breast Discharge ____YES ___NO
Cochlear Implant ____YES ___NO

Previous Studies: Yes No **STAT Studies:** Yes No

Physician Diagnosis _____

Limitation/ Notes _____

_____