OREGON IMAGING CENTERS

Patient Name: _____
Accession Number# _____ DOB: _____
Medical Record # _____ Date: _____

PLEASE INDICATE IF YOU HAVE ANY OF THE FOLLOWING

☐ YES	☐ NO	Cardiac Pacemaker	
☐ YES	☐ NO	Cardioverter Defibrillator	
☐ YES	☐ NO	History of metal in your eye(s) or had metal removed from your eye(s)?	
☐ YES	☐ NO	Metallic Object/Foreign Body	
☐ YES	☐ NO	Eyelid Springs or Wire	
☐ YES	☐ NO	**Implants**; Electronic, Wire Mesh, Cochlear or other Ear?	
☐ YES	☐ NO	**Implants**: Magnetically-Activated, or Drug Infusion Device or Other?	
☐ YES	☐ NO	Aneurysm Clips, Surgical Clips or Other?	
☐ YES	☐ NO	**Stimulators**; Neurostimulator System, Spinal Cord Stimulator or Bone Growth/Fusion	
☐ YES	☐ NO	Internal Electrodes or Wires?	
☐ YES	☐ NO	Metallic Stent, Filter or Coil	
☐ YES	☐ NO	Shunt (Spinal or Intraventricular)	
☐ YES	☐ NO	Vascular Access Port or Catheter	
☐ YES	☐ NO	Infusion Pump	
☐ YES	☐ NO	Heart Valve Prosthesis	
☐ YES	☐ NO	Prosthesis (eye, penile, etc.)?	
☐ YES	☐ NO	Tissue Expander	
☐ YES	☐ NO	Tattoo or Permanent Make-up	
☐ YES	☐ NO	Orthopedic Hardware (pins, plates, or screws)	
☐ YES	☐ NO	Other?	

Please Indicate Your Complete Medical and Surgical History

Allergies: ☐ Benadryl ☐ MRI Contrast ☐ Prednisone ☐ Epinephrine ☐ Latex ☐ Tape
☐ None Apply

Medical History (Please Check All That Apply)

☐ Seizures ☐ Kidney Disease
☐ Disease that Affects the Blood ☐ Diabetes ☐ High Blood Pressure
☐ None Apply ☐ Anemia ☐ Asthma/Respiratory Disease

Female Patients Only

☐ YES ☐ NO Currently Pregnant? ☐ YES ☐ NO IUD, Diaphragm, Pessary
☐ YES ☐ NO Breast feeding

MRI Technologist-Remove The Following Prior To Placing The Patient IN The Room

☐ Insulin Pump ☐ Prosthetic Limb ☐ Medication Patch ☐ Dentures/Partials
☐ Hearing Aid(s) ☐ Body Piercing Jewelry

Patient Acknowledgment

I attest that the above information is correct to the best of my knowledge. I have read and understand the contents of this form and had an opportunity to ask questions regarding the information on this form and the MRI procedure that I am about to undergo.

Patient Signature: _____ *Technologist Signature* _____

Guardian Signature: _____ *Date:* _____