KENTUCKY ORTHOPAEDICS & SPINE

Name_____ Date_____
Date of Birth_____ Age_____ ❑Male ❑Female Weight_____
Referring Physician_____ Family Physician_____
Reason for MRI and/or Symptoms_____

1. Have you ever had prior surgery/operation of any kind? ❑No ❑Yes
   If yes, please indicate the date and type of surgery:
   Date_____ Type of surgery_____
   Date_____ Type of surgery_____
2. Have you experienced any problems related to previous MRI? ❑No ❑Yes
   If yes, please describe:_____
3. Have you had an injury to the eye involving a metallic object or fragment (metallic slivers, shavings, foreign body, etc.)?
   ❑No ❑Yes
   If yes, please describe:_____
4. Have you ever been injured by a metallic object or foreign body (BB, bullet, shrapnel, etc.)?
   ❑No ❑Yes If yes, please describe:_____
5. Are you currently taking or have you recently taken any medication or drug for renal disease or diabetes? ❑No ❑Yes
   If yes, please list:_____
6. Are you allergic to any medication? ❑No ❑Yes
   If yes, please list:_____

For female patients:
Are you pregnant or experiencing a late menstrual period? ❑No ❑Yes
Are you currently breastfeeding? ❑No ❑Yes

Please answer all of the following:

❑No ❑Yes Aneurysm clip(s)
❑No ❑Yes Cardiac pacemaker
❑No ❑Yes Implanted cardioverter defibrillator (ICD)
❑No ❑Yes Electronic implant or device
❑No ❑Yes Magnetically-activated implant device
❑No ❑Yes Neurostimulator system
❑No ❑Yes Spinal cord stimulator
❑No ❑Yes Internal electrodes or wires
❑No ❑Yes Bone growth/bone fusion stimulator
❑No ❑Yes Cochlear, otologic, or other ear implant
❑No ❑Yes Insulin or other infusion pump
❑No ❑Yes Implanted drug infusion device
❑No ❑Yes Any type of prosthesis (eye, penile, etc.)
❑No ❑Yes Heart valve prosthesis
❑No ❑Yes Eyelid spring or wire
❑No ❑Yes Artificial or prosthetic limb
❑No ❑Yes Metallic stent, filter, or coil
❑No ❑Yes Shunt (spinal or intraventricular)
❑No ❑Yes Other implant_____
❑No ❑Yes Hearing aid **(Remove before entering MRI system room)**

❑No ❑Yes Vascular access port and/or catheter
❑No ❑Yes Radiation seeds or implants
❑No ❑Yes Swan-Ganz or thermodilution catheter
❑No ❑Yes Medication patch (Nicotine, Nitroglycerine)
❑No ❑Yes Any metallic fragment or foreign body
❑No ❑Yes Wire mesh implant
❑No ❑Yes Tissue expander (e.g. breast)
❑No ❑Yes Surgical staples, clips, or metallic sutures
❑No ❑Yes Joint replacement (hip, knee, etc.)
❑No ❑Yes Bone/Joint pin, screw, nail, wire, plate, etc.
❑No ❑Yes IUD, diaphragm, or pessary
❑No ❑Yes Dentures or partial plates
❑No ❑Yes Tattoo or permanent makeup
❑No ❑Yes Body piercing jewelry
❑No ❑Yes Breathing problem or motion disorder
❑No ❑Yes Claustrophobia
❑No ❑Yes Dexcom or glucose monitor device

I attest 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 and regarding the MR procedure that I am about to undergo.

Signature of Person Completing form:_____ **Date**_____
Form completed by:_____ **Relationship to patient**_____
MRI Technologist:_____ **Signature:**_____