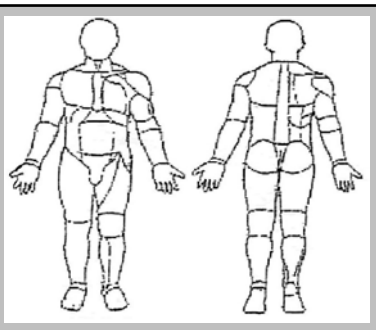
ENVISION IMAGING

# Patient MRI/CT History Form

**Patient Name: _____ Date of Birth:_____**

| Do you have any of the following items in your body? | | | |
|---|---|---|---|
| Pacemaker / Defibrillator /Pacer Wires | YES | NO | |
| Ear Surgery/Cochlear Implant/Hearing Aids | YES | NO | |
| Brain Aneurysm Clips or Coils | YES | NO | |
| Any metal / foreign body removed from eyes | YES | NO | |
| Gun Shot Wound, Shrapnel, or Metal Fragments in body | YES | NO | |
| Implanted electrical devices Pain Pump/Insulin Pump | YES | NO | |
| Any other Implants | YES | NO | |
| Tattoos/Permanent Make-up/Body Piercings | YES | NO | |
| Colonoscopy/Endoscopy/Gastric Scope | YES | NO | If Yes, Date performed:_____ |
| *If YES, were clips placed in the GI Tract* | YES | NO | If Yes, Date performed:_____ |
| Brain Shunt | YES | NO | |
| Neurostimulators | YES | NO | |
| Stents in Heart /Legs / Kidneys /Other | YES | NO | |
| Dentures held in with magnets | YES | NO | |
| Any Transdermal Patches (medication patches) | YES | NO | (If Yes, needs to be removed prior to MRI) |

| Do you have any History of the following? | | |
|---|---|---|
| History of Myeloma / Multiple Myeloma? | YES | NO |
| Liver transplant or failure? | YES | NO |
| Are you Diabetic (type I or II)? | YES | NO |
| Asthma? | YES | NO |
| History of KIDNEY FAILURE, Kidney surgery, or Kidney Cancer? | YES | NO |
| Are you currently on dialysis / blood transfusion? | YES | NO |
| Do you take any medication for hypertension (high blood pressure)? | YES | NO |
| Heart Failure / Heart Surgery | YES | NO |
| Are you on any blood thinners? | YES | NO |
| Are you taking any of the following: (*If yes, Circle Medication below*) Glucophage, Glucovance, Metformin, Actos Plus Met, Avandamet, Fortamet, Metaglip, Glumetza, Riomet, or Janumet? | YES | NO |
| **FOR SPINE EXAMS**: Any Leg or Arm Pain? | YES | NO |



**Please Mark Area of Pain**

| *FEMALE PATIENTS ONLY:* | | | | |
|---|---|---|---|---|
| Any possibility of being pregnant? | YES | NO | Patient Initials_____ | Tech Initials_____ |
| Are you breast feeding? | YES | NO | Patient Initials_____ | Tech Initials_____ |

Have you ever had an Injection of Contrast? YES NO

*If Yes, Did you experience an allergic reaction to Contrast* (***Please Explain***) _____

List drug allergies: _____

List of other Medications that you are currently taking: _____

Current Weight: _____

Please list previous surgeries: _____

**Signature of Patient/guardian:_____ Date___/___/_____**

**Technologist/Witness Signature: _____ Date:___/___/_____**