SIRA Imaging Center, LLC

MRI Health History Sheet

Patient Name:_____**DOB:**_____

Ordering Physician:_____**Date:**_____

No **Yes** Have you had any previous brain or aneurysm surgery?

No **Yes** Have you had any heart surgery, pacemaker, wires, or defibrillator?

No **Yes** Do you have a history of metal in eyes or exposure to metal?

No **Yes** Have you had any inner ear surgery? (Prosthesis or cochlea, or stapes implant)

No **Yes** Do you have a penile implant?

No **Yes** Are you pregnant or breast feeding?

List any surgeries you have had within the last **six weeks**_____

_____

_____

No **Yes** Have you ever had cancer? (If yes, what type?_____)

What type of treatment? **(circle applicable treatments)**

Surgery Radiation Chemotherapy

Are you taking any bone marrow stimulating drugs? **(circle name)**

Neupogen Filgrastim Leukine Epogen

No **Yes** Have you ever had asthma?

No **Yes** Have you ever had allergic reaction to MRI contrast?

Please list any allergies:_____