JOHNSON COUNTY IMAGING

**Name:** ___________________________ **Pt ID:** ______________ **Height:** _______ **Weight:**__________

**Date of birth:** __/__/__ **Age:** ___ **Exam:** ______________**Ordering Physician**_____________________

**Reason/Symptoms for MRI:** _________________________________________________________________

_________________________________________________________________________________________

_________________________________________________________________________________________

**How long have you had these symptoms?** _____________________________________________

**Are these symptoms due to an injury? Please describe:** ______________________________________

_________________________________________________________________________________________

**Have you had surgery on the body part being scanned?** YES NO

**If "YES", where and when?** ______________________________________________________________

**Have you had prior imaging done on this area (MRI, CT, XRay, etc)?** YES NO

**If "YES", where and when?** ______________________________________________________________

**Are you allergic to latex?** YES NO

**Please list any drug allergies:** _____________________________________________________________

*Please mark YES or NO to the following questions:*

| | | | | | |
|---|---|---|---|---|---|
| Heart Surgery | YES | NO | Hearing Aids | YES | NO |
| Pacemaker, Wires, Defibrillator | YES | NO | Eye or Ear Implants | YES | NO |
| Coronary Stent | YES | NO | Metal Shavings in Eye | YES | NO |
| Brain Surgery | YES | NO | Bullets/BB's Shrapnel | YES | NO |
| Brain or Surgical Clips | YES | NO | Magnetic Implants | YES | NO |
| Shunt | YES | NO | Medication Patch | YES | NO |
| Aneurysm Surgery | YES | NO | Body Piercings | YES | NO |
| Artificial Limb or Joint | YES | NO | Wig or Hair Piece | YES | NO |
| Plates/Pins/Screws/Staples | YES | NO | Insulin/Infusion Pump | YES | NO |
| Electric Stimulator for nerves/pain | YES | NO | Claustrophobic | YES | NO |
| Permanent Make up/Tattoos | YES | NO | Could you be pregnant? | YES | NO |
| Dentures/Partials/Retainer | YES | NO | Are you breastfeeding? | YES | NO |
| Are you diabetic? | YES | NO | Are you on dialysis? | YES | NO |
| Taking high blood pressure meds? | YES | NO | History of renal disease? | YES | NO |
| History of kidney transplant? | YES | NO | History of kidney cancer? | YES | NO |
| Do you have a single kidney? | YES | NO | Any kidney surgery? | YES | NO |
| Do you have a history of cancer? | YES | NO | If "YES", type & year diagnosed: ________________________ | | |

**Have you had a colonoscopy in the last 30 days?** YES NO

**Have you been hospitalized in the last 30 days for dehydration, febrile illness, sepsis, heart failure, liver disease or abdominal surgery?** YES NO

**Signature of Patient/Guardian:** ___________________________ *If guardian, relationship to patient*________________

**Date:** ________________________

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*For office use only*

*Contrast:* ________*cc's of* ________________________ *Lot#* ________________________

*Technologist Signature*: ____________________________**Date:**_____________________________________________________

*Tech Notes*:_____________________________________________________________________________________________