Longview Radiologists, P.S. Inc.
700 Lincoln St. Suite 100, Kelso, WA. 98626

PATIENT NAME____

PROCEDURE____

THE FOLLOWING ITEMS CAN INTERFERE WITH MRI IMAGING AND SOME MAY BE HAZARDOUS TO YOUR SAFETY. PLEASE READ CAREFULLY.

YES	NO	
______	______	CARDIAC PACEMAKER
______	______	ANEURYSM / METAL CLIPS FROM BRAIN SURGERY
______	______	DO YOU HAVE ANY STENTS OR INTRAVENOUS FILTERS?
______	______	HAVE YOU EVER HAD ANY HEART OR BRAIN SURGERY?
______	______	A. If yes, please explain. ______________________________
______	______	DO YOU HAVE ANY INTERNAL OR EXTERNAL PAIN PUMPS / INSULIN PUMP?
______	______	HAVE YOU EVER HAD METAL FRAGMENTS DETECTED IN YOUR EYES?
______	______	HAVE YOU EVER PERFORMED WELDING OR GRINDING?
______	______	A. If yes, did you wear eye protection 100 % of the time?
______	______	METAL IN BODY (from surgeries, shrapnel from wartime activity or gunshot wound)
______	______	HAVE YOU EVER HAD SURGERY ON THE BODY PART BEING SCANNED?
______	______	IF YES, WHAT FACILITYAND WHEN?______________________________
______	______	HEARING AID
______	______	REMOVABLE DENTURES OR ORAL APPLIANCES
______	______	OTHER METAL IMPLANTS (please explain) ______________________________
______	______	HAVE YOU BEEN DIAGNOSED WITH CANCER
______	______	A. If so, what type of cancer?______________________________
______	______	ARE YOU PREGNANT?
______	______	ARE YOU CURRENTLY NURSING?
______	______	DO YOU HAVE AN IUD IMPLANT? IF YES, WHAT TYPE____________________
______	______	DO YOU HAVE ANY PERMANENT TATTOOS OR PERMANENT EYELINER?
______	______	ARE YOU CLAUSTROPHOBIC?

Weight ________

SIGNATURE of patient or representative______________________________________

RELATIONSHIP to patient____

Date__________________________ **Time**__________________________

TECHNOLOGIST USE ONLY HISTORY:

Tech initials__________________