Pt #_____

Name_____ Date_____

Referring Physician_____

Type of MRI/MRA (body part)_____ Age_____

1. Have you ever been a metal worker, machinist or cut or grind any metal? **YES NO**
   If yes, did you wear protective eye covering?
   N/A YES NO
   Have you ever had a penetrating eye injury? **YES NO**
2. Is there any possibility you are pregnant? **YES NO**
   Last Menstrual Period:_____
3. Are you breast feeding? **YES NO**
4. Do you have a transdermal patch (i.e.: nicotine or pain patch) **YES NO**
5. Are you wearing "magneto" or magnetic gel-nail polish? **YES NO**
6. Have you recently traveled? **YES NO**
7. List any surgery you have had :
   _____

8. If you have a PACEMAKER? Y or N
9. If yes, is it after APRIL 1, 2012? Y or N
10. Is the make Medtronic? Y or N
11. Model ? Advisa or Revo
12. Lead Model Number: _____

Please describe your present symptoms:

_____

_____

Please list other diagnostic tests relating to this problem:

_____

_____

For Office Use Only:
Technologist Initials_____ **Date:**_____

Do you have:	**Yes**	**No**	**Date of Implant**
Cerebral Aneurysm Clips	_____	_____	_____
Abdominal Aneurysm	_____	_____	_____
Pacemaker	_____	_____	_____
Defibrillator	_____	_____	_____
Tissue Expander	_____	_____	_____
IUD	_____	_____	_____
Shrapnel (bullets)	_____	_____	_____
Stents	_____	_____	_____
Any Metal Implant	_____	_____	_____
Heart Valve	_____	_____	_____
Neuro Stimulator	_____	_____	_____
Hearing Aid	_____	_____	_____
Cochlear Implant (ear implant)	_____	_____	_____
Shunt	_____	_____	_____
Portacath	_____	_____	_____
Any other metals	_____	_____	_____
Greenfield Filter (IVC)	_____	_____	_____

If you have these, please notify technologist

Personal Medical History:	**Yes**	**No**
Renal Failure/Disease	_____	_____
Claustrophobia	_____	_____

Patient Signature_____

Date:_____

Tech/Witness signature:_____

WE NOW OFFER 3D MAMMOGRAPHY AT OUR ROUTE 46 LOCATION