Maryland MRI, L.L.C.
Clinical Form

Please Print

MRI _____ **MRA** _____	☐ **Without contrast** ☐ **Without and With contrast** ☐ **With contrast only**

Name: _____ Date of Birth: ____/____/____
Last First Middle Initial Month Day Year

Sex: ☐ Male Last four digits of social security # _____ Height: _____ft. _____ins.

☐ Female Are you pregnant? ☐ No ☐ Yes Weight: _____

Please explain in detail why you are having this exam (what is the problem, how long, any pain, mass, etc.): _____

_____

Do you have a history of, or suspected, demyelinating disease of the brain e.g. multiple sclerosis ☐ No ☐ Yes If Yes, please explain:

_____

Are you experiencing any tingling or numbness? ☐ No ☐ Yes If Yes, please explain:_____

Any prior surgery (to area being scanned)? ☐ No ☐ Yes If Yes, list type and date:_____

Any prior exams (to area being scanned)? ☐ No ☐ Yes If Yes, list type and date:_____

Were you in an accident? ☐ No ☐ Yes If Yes ☐ Automobile ☐ Work related ☐ Other _____Date of injury: ____/____/____

Any internal derangement (injury), dysfunction, of the joints? ☐ No ☐ Yes If Yes, please explain:_____

Do you have any history of cancer? ☐ No ☐ Yes If Yes, please explain:_____

Have you had an allergic reaction to contrast? ☐ No ☐ Yes If Yes, please explain:_____

The following items may be hazardous or may cause interference with the MRI examination by producing artifacts. Please indicate if you have any of the following:

Aneurysm Clip(s)	Y ☐ N ☐	Intraventricular Shunt	Y ☐ N ☐
Artificial Limbs/ Joints	Y ☐ N ☐	IUD	Y ☐ N ☐
Biostimulator	Y ☐ N ☐	Mechanical/Electrical/ Magnetic Implants	Y ☐ N ☐
Body Piercing	Y ☐ N ☐	Neurostimulator	Y ☐ N ☐
Braces	Y ☐ N ☐	Pacing Wires	Y ☐ N ☐
Cardiac Defibrillator	Y ☐ N ☐	Pessary	Y ☐ N ☐
Cardiac Pacemaker	Y ☐ N ☐	Pins/ Rods/ Screws/	Y ☐ N ☐
Clips/ Plates/ Wire Mesh	Y ☐ N ☐	Prosthesis (other than Limbs/Joints)	Y ☐ N ☐
Dentures	Y ☐ N ☐	Shrapnel	Y ☐ N ☐
Diaphragm	Y ☐ N ☐	Stent(s)	Y ☐ N ☐
Drug Infusion Device	Y ☐ N ☐	Swan-Gans Catheter	Y ☐ N ☐
Hearing Aid	Y ☐ N ☐	Tattoos	Y ☐ N ☐
Insulin Pump	Y ☐ N ☐	Other (please list) :_____	

If yes to any of the above please explain: _____

_____ _____ _____
Patient/Parent/Legal Guardian Signature Technologist Signature Date

Office use only

Type of Contrast	Quantity	Site of Injection	Time of Injection	Lot Number	Expiration