

# Garden Grove MRI Center

Name \_\_\_\_\_ Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_

Have you ever had an operation or surgical procedure of any kind? Yes \_\_\_\_\_ No \_\_\_\_\_

Please list all with dates:

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Yes \_\_\_ No \_\_\_ **Pacemaker**, Wires, or Defibrillator Yes \_\_\_ No \_\_\_ Pregnant? Date of last period \_\_\_\_\_

Yes \_\_\_ No \_\_\_ Brain/Aneurysm Clips Yes \_\_\_ No \_\_\_ Artificial Limb or Joint

Yes \_\_\_ No \_\_\_ Ear Implants Yes \_\_\_ No \_\_\_ Permanent Eyeliner Tattoo

Yes \_\_\_ No \_\_\_ Eye Implants or Cataracts Yes \_\_\_ No \_\_\_ Implanted Catheter or Tube

Yes \_\_\_ No \_\_\_ Electrical or Nerve Stimulators Yes \_\_\_ No \_\_\_ Artificial Heart Valve

Yes \_\_\_ No \_\_\_ Metal Shrapnel or Fragments Yes \_\_\_ No \_\_\_ Penile Prosthesis

Yes \_\_\_ No \_\_\_ Magnetic Implants Any where Yes \_\_\_ No \_\_\_ Infusion Pump

Yes \_\_\_ No \_\_\_ Have ever been hit in the eye with shrapnel Yes \_\_\_ No \_\_\_ Coil, Filters, or Wire in blood vessel

Yes \_\_\_ No \_\_\_ Have you had shrapnel remove from eye Yes \_\_\_ No \_\_\_ Stent, When? \_\_\_\_\_

Yes \_\_\_ No \_\_\_ Diaphragm or intrauterine device Yes \_\_\_ No \_\_\_ Shunt

Yes \_\_\_ No \_\_\_ False Teeth, Retainers or Magnetic braces Yes \_\_\_ No \_\_\_ Surgical clips, staples,

Yes \_\_\_ No \_\_\_ **Any history of kidney disease or dialysis**

## INFORMATION ABOUT GADOLINIUM CONTRAST INJECTIONS:

As part of your examination, it may be necessary to give you an intravenous (I.V.) injection of a contrast agent containing gadolinium. This injection may help the MRI radiologist more accurately diagnose your condition. Although gadolinium contrast agents have used safely in millions of cases, minor reactions (principally headaches or nausea) occur in about 2% of patients. Serious or life threatening reactions have reported in about one in 400,000 patients.

Gadolinium Contrast is also known to induce Nephrogenic Fibrosing Dermopathy in a small percentage of the patients with moderate to end stage kidney disease.

I attest that the answers I have provided to questions on this form are correct to the best of my knowledge. I have read and understand the entire contents of this form and have opportunity to ask questions regarding the information on this form.

Signature (Patient or Guardian): \_\_\_\_\_ Date \_\_\_\_\_

Patient's Nurse: \_\_\_\_\_ MRI Technologist \_\_\_\_\_

**PILOT**

