

**ROME MEMORIAL HOSPITAL**

1500 North James Street, Rome, New York 13440

Have you ever had surgery?  Yes  No

If yes, please list types and dates: \_\_\_\_\_

Have you had any surgical procedures in the last 6 weeks?  Yes  No

If yes, please list types and dates: \_\_\_\_\_

Have you ever worked with metal (grinding, fabrication, machine shop)?  Yes  No

Have you ever had any metallic objects in your eyes (slivers, foreign body, etc.)?  Yes  No

If yes, please describe: \_\_\_\_\_

Do you have any food or medication allergies:  Yes  No

If yes, please list: \_\_\_\_\_

Do you have or have you ever had a detached retina (eye)?  Yes  No

Do you have kidney disease?  Yes  No

Are you currently undergoing dialysis treatment?  Yes  No

Have you had or are you scheduled to have a liver transplant?  Yes  No

Have you had an Endoscopy procedure in the last year?  Yes  No

**For Female Patients:** Are you pregnant or experiencing a late menstrual period?  Yes  No

Are you breast feeding?  Yes  No

Breast Implants? \_\_\_\_\_  Yes  No

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Cardiac Pacemaker (heart)                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Transdermal Delivery System (NITRO)      |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Implanted Cardiac Defibrillator (heart)    | <input type="checkbox"/> Yes <input type="checkbox"/> No | IUD or Diaphragm                         |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Aneurysm Clip(s) (brain, abdomen)          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tattooed Makeup (eyeliner, lips, etc.)   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Carotid Artery Vascular Clamp              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Body Piercing(s)                         |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Neurostimulator                            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Any Metal Fragments                      |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Insulin or Infusion Pump                   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Internal Pacing Wires (heart)            |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Implanted Drug infusion Device             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Metal or Wire Mesh Implants              |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Bone Growth/Fusion Stimulator              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Wire Sutures or Surgical Staples         |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Ear Surgery or Implant                     | <input type="checkbox"/> Yes <input type="checkbox"/> No | Harrington Rods (spine)                  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Any Type of Prosthesis (eye, penile, etc.) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Joint Replacement _____                  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Valve Prosthesis                     | <input type="checkbox"/> Yes <input type="checkbox"/> No | Bone/Joint Pin, Screw, Nail, Wire, Plate |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Artificial Limb or Joint                   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hearing Aid (Remove before MRI)          |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Electrode (on body, head, or brain)        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Dentures (Remove before MRI)             |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Intravascular Stents, Filters, or Coils    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Breathing Disorder                       |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Shunt (spinal or intraventricular)         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Claustrophobia or Anxiety                |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Vascular Access Port and/or Catheter       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Blood/Body Fluid/Infection Control       |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Swan-Ganz Catheter                         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Precautions (TB/MRSA, etc.)              |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Any Implant Held in Place By a Magnet      |  |  |

I attest that the above information is correct to the best of my knowledge. I read and understand the contents of the form and had the opportunity to ask questions regarding the information on this form and regarding the MR procedure that I am about to undergo.

\_\_\_\_\_  
Patient/Health Care Agent/Surrogate Decision Maker Signature Date/Time

\_\_\_\_\_  
Interpreter Signature (If Required) Date/Time

\_\_\_\_\_  
History Reviewed By Signature Date/Time

\_\_\_\_\_  
Reviewing Technologist Signature Date/Time

