HEART OF TEXAS
HEALTHCARESYSTEM
2008 Nine Road • Brady TX 76825-1150 • 325.597.2901

PATIENT NAME: _____ **WEIGHT:**_____

DATE OF BIRTH: _____/_____/_____

Please indicate if you have any of the following:

DO YOU HAVE KIDNEY DISEASE OR A RENAL HISTORY?	☐ Yes	☐ No
IF YES, ARE YOU ON DIALYSIS?	☐ Yes	☐ No
Do you think you may be **pregnant**?	☐ Yes	☐ No
Claustrophobia	☐ Yes	☐ No
CARDIAC PACEMAKER/DEFIBRILLATOR	☐ Yes	☐ No
ANEURYSM CLIP(S)	☐ Yes	☐ No
Electronic implant or device	☐ Yes	☐ No
Ever had metal in eyes	☐ Yes	☐ No
Heart valve prosthesis	☐ Yes	☐ No
Metallic stent, filter, or coil	☐ Yes	☐ No
Cochlear, otologic, or other ear implant	☐ Yes	☐ No
Implanted drug infusion device	☐ Yes	☐ No
Internal electrodes or wires	☐ Yes	☐ No
Bone growth/bone fusion stimulator	☐ Yes	☐ No
Any type of prosthesis (eye, penile, etc.)	☐ Yes	☐ No
Artificial or prosthetic limb	☐ Yes	☐ No
Shunt (spinal or intraventricular)	☐ Yes	☐ No
Eyelid spring or wire	☐ Yes	☐ No
Swan-Ganz (ICU)	☐ Yes	☐ No
Tissue expander (e.g. breast)	☐ Yes	☐ No
Medication patch (Nicotine, Nitroglycerine)	☐ Yes	☐ No
Any metal implants, metallic fragments or foreign bodies	☐ Yes	☐ No
Tattoo or permanent makeup	☐ Yes	☐ No
Dentures or partial plates	☐ Yes	☐ No
Body piercing jewelry	☐ Yes	☐ No
Hearing aid (*remove before entering MR system room*)	☐ Yes	☐ No
HAVE YOU HAD ANY PREVIOUS MRI STUDIES?	☐ Yes	☐ No
HAVE YOU EVER BEEN DIAGNOSED WITH CANCER?	☐ Yes	☐ No
HAVE YOU HAD SURGERY ON THE AREA BEING STUDIED TODAY?	☐ Yes	☐ No
HAVE YOU HAD ANY SURGERY WITHIN THE LAST 8 WEEKS?	☐ Yes	☐ No
DO YOU HAVE ANY ENDOSCOPY CLIPS?	☐ Yes	☐ No

PATIENT CONSENT FORM AND ACKNOWLEDGMENT OF METAL IMPLANTS

I hereby state that besides my teeth, there is no metal that has been surgically placed in my body that has not been disclosed above. I also state that I have had no injuries whereby iron shavings or shrapnel are imbedded in my body, particularly my eyes, I have read this questionnaire in its entirety and filled it out to the best of my knowledge. I thereby consent to this MRI examination.

_____ _____ _____

Signature of patient Date Technologist