CASTRO VALLEY
OPEN MRI

Date _____

PATIENT HISTORY

Patient Name: _____ **Sex:** ☐**M** ☐**F**

Wt: _____ **Ht:**_____**D.O.B.**: _____**Age:** _____**Referring Physician**: _____

Reason you are here today? (Explain your medical problem in detail…. What is the problem? Where is the problem? How long have you had this problem?

_____

Is your problem related to an injury?☐**Yes** ☐**No** **If yes, Date of Injury?** _____

Have you had a previous MRI or CT related to this exam? ☐**Yes** ☐**No** **If Yes, please explain**:

_____

Have you taken any sedation to relax you for this procedure? ☐**Yes** ☐**No** **If Yes, What?**_____

If yes, do you have someone to drive you home? ☐**Yes**☐**No**

CONTRAST HISTORY

Have you ever had MRI contrast? ☐**Yes** ☐**No** **Did you have any kind of reaction?** ☐**Yes** ☐**No** **If yes, explain:**

_____

Are you Breast feeding at this time? ☐**Yes** ☐**No**

Do you have anemia or any disease(s) that affects your blood, a history of renal disease, or seizures? ☐**Yes** ☐ **No**

If Yes, please explain: _____

ALLERGIES

List any Drug Allergies: _____

List previous Surgeries: _____

Medications presently taking:_____

I have answered these questions to the best of my knowledge and understand the information presented to me. I have also informed the technologist that I am not pregnant at this time.

_____ _____ _____

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