THE BATON ROUGE CLINIC AMC

Magnetic Resonance (MR) Procedure History Form for Patients

7373 Perkins Road ¥ Baton Rouge, Louisiana 70808-4326 ¥ (225) 769-4044

Date ____/____/____ Patient Number _____

Name: _____ Age: _____ Height: _____ Weight: _____

Date of Birth ____/____/____ Male ❑ Female ❑

Reason for MRI and/or Symptoms: _____

Referring Physician: _____

1. Have you had prior surgery or an operation (e.g., arthroscopy, endoscopy, etc.) of any kind? ❑ Yes ❑ No
   If yes, please indicate the date and type of surgery:
   Date ____/____/____ Type of surgery _____
   Date ____/____/____ Type of surgery _____
2. Have you had a prior diagnostic imaging study or examination (MRI, CT, Ultrasound, X-ray, etc.)? ❑ Yes ❑ No
   Have you ever received a contrast agent/x-ray dye used for MRI, CT, or other x-ray or study? ❑ Yes ❑ No
   Have you ever had an x-ray or magnetic resonance imaging (MRI) contrast agent allergic reaction? ❑ Yes ❑ No
   If YES, please describe: _____
3. Have you experienced any problem related to a previous MRI examination or MR procedure? ❑ Yes ❑ No
   If yes, please describe: _____
4. Have you had an injury to the eye involving a metallic object or fragment (e.g., metallic slivers, shavings, foreign body, etc? ❑ Yes ❑ No
   If yes, please describe: _____
5. Have you ever been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel, etc.)? ❑ Yes ❑ No
   If yes, please describe: _____
6. Have you ever done: Welding? Grinding? Machine work? Metal Lathe work? ❑ Yes ❑ No
   If yes, please specify: _____
7. Are you currently taking or have you recently taken any medication or drug? ❑ Yes ❑ No
   If yes, please list: _____
8. Are you allergic to any medication? ❑ Yes ❑ No
   If yes, please list: _____
9. Do you have a history of asthma, allergic reaction, respiratory disease, or reaction to a contrast medium or dye used for an MRI, CT, or X-ray examination? ❑ Yes ❑ No
10. Do you have anemia or any disease(s) that affects your blood, a history of renal (kidney) disease, or seizures? ❑ Yes ❑ No
    If yes, please describe: _____

For female patients:

11. Date of last menstrual period: ____/____/____ Post menopausal? ❑ Yes ❑ No
12. Are you pregnant or experiencing a late menstrual period? ❑ Yes ❑ No
13. Are you taking oral contraceptives or receiving hormonal treatment? ❑ Yes ❑ No
14. Are you taking any type of fertility medication or having fertility treatments? ❑ Yes ❑ No
    If yes, please describe: _____
15. Are you currently breastfeeding? ❑ Yes ❑ No