

PATIENT NAME: _____ **DATE OF BIRTH:** _____

What is your current weight (Lbs): _____

Past or current injury to the eye involving a metallic object? **YES NO**

Have you ever been injured by a metallic object/foreign body (BB, bullet, shrapnel)? **YES NO**

Currently pregnant or breastfeeding? **YES NO**

Eye, Ear, Brain, or Heart surgery? Explain: _____

What is the reason for having this MRI? _____

Prior breast imaging and where? _____

Please give date and type of **any** surgery _____

Have you had a breast biopsy, lumpectomy, mastectomy, radiation, reduction? If yes, when/what side/result?

Are you a BRAC1 OR BRAC2 Carrier? **YES NO** Have you taken hormone replacement therapy? **YES NO**

Are you postmenopausal? **YES NO** If yes, what age? _____

List all personal cancer history including breast & year diagnosed _____

Please list food or drug allergies: _____

Please circle if you have any of the following:

- | | | |
|------------------------------------|---------------------------------------|-------------------------------------|
| Aneurysm Clips/Brain Clips | Any type prosthesis (eye, limb, etc.) | |
| Body/dermal piercing | Bone growth/bone stimulator | Bone joint, screw, nail, pin, etc. |
| Cardiac Pacemaker or Defibrillator | Cochlear implant | Continuous Glucose Monitor |
| Dentures or partial plates | Hearing Aid | Insulin/Infusion Pump |
| Internal electrodes/wires | IUD, diaphragm, pessary | Joint replacement (hip, knee, etc.) |
| Medication Patch | Metallic stent, filter, coil or graph | Port or catheter |
| Shunt (brain or spine) | Spinal cord or neuro stimulator | Surgical staples, clips, sutures |
| Tattoo or permanent makeup | Tissue expanders (e.g.) breast | Swallowed Pill Camera |

WARNING: Certain Implants, devices, or objects may be hazardous to you in the MRI room. DO NOT ENTER the MRI room if you have any question or concern regarding an implant, device, or object. Please consult the MRI Technologist or Radiologist if you have any questions or concerns BEFORE you enter the MR system room. I attest that the above information is correct to the best of my knowledge. I have read and understand the entire contents of this form and will ask questions regarding the information on this form.

PATIENT SIGNATURE: _____ DATE: _____

TECHNOLOGIST SIGNATURE: _____