Health Village Imaging
A Member of the Hackensack Meridian Health Network

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

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

What is the reason for having this MRI?_____

Prior diagnostic imaging **of the Prostate** and where? _____

Did you have a prostate biopsy, prostatectomy or pelvis surgery? If, so where/when? _____

What was your prostate biopsy Gleason Score? _____ What is you **PSA**? _____

Please give date and type of **any** surgery_____

List all personal cancer history: _____

Please list food or drug allergies: _____

Please circle if you have any of the following:

Aneurysm Clips/Brain Clips	Any type prosthesis (eye, limb, penile, 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: _____