

**Longview Radiologists, P.S. Inc.**  
**700 Lincoln St. Suite 100, Kelso, WA. 98626**

PATIENT NAME \_\_\_\_\_

PROCEDURE \_\_\_\_\_

**THE FOLLOWING ITEMS CAN INTERFERE WITH MRI IMAGING  
AND SOME MAY BE HAZARDOUS TO YOUR SAFETY.  
PLEASE READ CAREFULLY.**

YES	NO	
_____	_____	CARDIAC PACEMAKER
_____	_____	ANEURYSM / METAL CLIPS FROM BRAIN SURGERY
_____	_____	DO YOU HAVE ANY STENTS OR INTRAVENOUS FILTERS?
_____	_____	HAVE YOU EVER HAD ANY HEART OR BRAIN SURGERY?
_____	_____	A. If yes, please explain. _____
_____	_____	DO YOU HAVE ANY INTERNAL OR EXTERNAL PAIN PUMPS / INSULIN PUMP?
_____	_____	HAVE YOU EVER HAD METAL FRAGMENTS DETECTED IN YOUR EYES?
_____	_____	HAVE YOU EVER PERFORMED WELDING OR GRINDING?
_____	_____	A. If yes, did you wear eye protection 100 % of the time?
_____	_____	METAL IN BODY (from surgeries, shrapnel from wartime activity or gunshot wound)
_____	_____	HAVE YOU EVER HAD SURGERY ON THE BODY PART BEING SCANNED?
_____	_____	IF YES, WHAT FACILITY AND WHEN? _____
_____	_____	HEARING AID
_____	_____	REMOVABLE DENTURES OR ORAL APPLIANCES
_____	_____	OTHER METAL IMPLANTS (please explain) _____
_____	_____	HAVE YOU BEEN DIAGNOSED WITH CANCER
_____	_____	A. If so, what type of cancer? _____
_____	_____	ARE YOU PREGNANT?
_____	_____	ARE YOU CURRENTLY NURSING?
_____	_____	DO YOU HAVE AN IUD IMPLANT? IF YES, WHAT TYPE _____
_____	_____	DO YOU HAVE ANY PERMANENT TATTOOS OR PERMANENT EYELINER?
_____	_____	ARE YOU CLAUSTROPHOBIC?

Weight \_\_\_\_\_

SIGNATURE of patient or representative \_\_\_\_\_

RELATIONSHIP to patient \_\_\_\_\_

Date \_\_\_\_\_

Time \_\_\_\_\_

<b>TECHNOLOGIST USE ONLY</b>  Tech initials _____	<b>HISTORY:</b>  
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