Rockledge MRI & PET Center

1910 Rockledge Blvd. Suite 102, Rockledge, FL 32955
P (321) 636-6599 F (321) 636-6614

MRI CLINICAL

Patient Name_____ Patient #_____

Height_____ Weight_____ When is follow up appt. with Dr.?_____

Previous surgery on area of scan? YES/NO If yes, what type?_____

Previous trauma/Accident? YES/NO Duration?_____ Type of injury?_____

Have you ever been diagnosed with cancer? YES/NO Type_____ Year_____

Body Part_____ Treatment SURGERY / RADIATION / CHEMO THERAPY

Are you claustrophobic? YES/NO Sedation? YES/NO Type? _____

Have you been exposed to metal in your eyes? YES/NO _____
Do you have any aneurysm clips? YES/NO _____
Do you have a Cardiac Pacemaker? YES/NO _____
Do you have any implanted stents? YES/NO _____
Do you have any ear surgeries / implants? YES/NO _____
Do you have any electronic stimulators or pumps? YES/NO _____
Do you have any permanent facial makeup? YES/NO _____
Are you pregnant or breastfeeding? YES/NO _____
Are you allergic to latex? YES/NO _____
Are you on any blood thinner medication? (Coumadin) YES/NO _____
Do you have any history of kidney disease? YES/NO _____
Are you over the age of 40? YES/NO _____

CREATININE RESULTS_____ RANGE_____-_____ TEST DATE_____

INR IF FOR ARTHROGRAM: _____ TEST DATE:_____

PRIOR STUDIES:
Scan Type_____ Area_____ Facility_____ Date_____
Scan Type_____ Area_____ Facility_____ Date_____
Scan Type_____ Area_____ Facility_____ Date_____

Staff Initial_____

Patient's Signature_____Date_____