



Rockledge MRI & PET Imaging Center

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MRI Clinical

Patient Name _____ Wt _____ Patient # _____

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 THRAPY

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

Have you ever 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 ear surgeries/implants? YES / NO _____

Do you have any electronic stumualtors 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 allergic to iodine? YES / NO _____

Are you on any blood thinner medications? YES / NO _____

Do you have any history of kidney disease? YES / NO _____

Are you 60 or older? YES / NO _____

CREATININE RESULTS _____ RANGE _____ - _____ 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 _____