Rockledge MRI & PET Imaging Center

1910 Rockledge Blvd Suite 102, Rockledge, FL 32955

MRI Clinical Information

Patient Name____ Age______

Height_________ Weight______

Reason for Exam (injury, accident, pain?)

____

Prior Studies of area being imaged? Yes No

Where? ____

Do you have any implants, metallic or otherwise in or on your body?

	YES	NO
Have you been exposed to metal in your eyes?		
Do you have any aneurysm clips?		
Do you have a Cardiac Pacemaker?		
Do you have any implanted stents?		
Do you any ear implants/hearing aids?		
Do you have any electronic simulators or pumps?		
Are you pregnant or breastfeeding?		
Are you allergic to latex?		
Do you have claustrophobia?		

Patient Signature_______________________________________ Date _____________

UPDATED 04/13/23