

Name _____
 Height _____ Weight _____
 Date of Birth ____/____/____ Age _____
 Race _____
 Phone (home/cell) _____
 Phone (work) _____
 Referring physician: _____

CBC Staff Use Only: Appt: _____
 ID Number _____
 Form filled out by: _____ Date: _____
 Reviewed by: _____
 Cr date: _____ Cr #: _____ GFR: _____
 MD approved: _____ Date: _____

Please indicate if you are or have a history of any of the following:

- | | |
|--|---|
| yes no Aneurysm clip(s) | yes no Over age 55 |
| yes no Ever had or currently have ANY implanted device such as a cardiac pacemaker or defibrillator (ICD), neurostimulator, insulin or drug infusion pump, cochlear implant, wire mesh implant, shunt (spinal or intraventricular), heart valve, joint replacement, etc. | yes no Kidney disease |
| yes no Ever had eye or face injury from metal | yes no Diabetes |
| yes no Ever had internal electrodes or wires | yes no Protein in urine |
| yes no Metallic stent, filter, or coil | yes no History of high blood pressure |
| yes no Any metallic fragment or foreign body | yes no Kidney transplant |
| yes no Vascular access port and/or catheter | yes no Do you take non-steroidal anti-inflammatory drugs such as aspirin, (Motrin, Advil), Naproxen (Aleve, Naprosyn), ketoprofen (Orudis), or celecoxib (Celebrex) multiple times daily? |
| yes no Tissue expander (e.g., breast) | yes no On dialysis |
| yes no IUD, diaphragm, or pessary | yes no Liver transplant |
| yes no Artificial or prosthetic limb or any other prosthesis (e.g., eye) | yes no Sickle cell disease |
| yes no Dentures or partial plates | yes no Hemolytic anemia |
| yes no Medication patch (Nicotine, Nitroglycerine) | yes no Breathing problems or asthma |
| yes no Tattoo or permanent makeup: _____ | yes no Problem lying on stomach for 30 min |
| yes no Body piercing jewelry: _____ | yes no Claustrophobia |
| yes no Hearing aid | yes no Motion disorder |
| yes no Other implanted metal or device: _____ | yes no Seizures |

Are you allergic to any medication? yes no
 If yes, please list: _____

Do you have any serious allergies that have caused hives, throat swelling, or breathing problems? yes no
 If yes, please describe: _____

Have you ever had a prior breast MRI? If so, when/where? _____ yes no

Do you have a history of allergic reaction, respiratory disease, or reaction to a contrast medium or dye used for an MRI, CT, or X-ray examination? yes no

Date of last menstrual period: ____/____/____	Are you or could you be pregnant?	yes no
Estimated date of next menstrual period: ____/____/____	Are you postmenopausal?	yes no
Are you taking oral contraceptives?		yes no
Are you taking hormonal treatment or hormone replacement?		yes no
Are you taking any type of fertility medication or having fertility treatments?		yes no
If yes, please describe: _____		
Are you currently breastfeeding?		yes no

I attest that the above information is correct to the best of my knowledge.

Patient signature _____ Date: _____ MR tech _____

Information has been reviewed, and any and all changes since previous MR study are noted

Patient signature _____ Date: _____ MR tech: _____

Patient signature _____ Date: _____ MR tech: _____