



TOWER IMAGING VALENCIA

Imaging by Specialists

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Telephone: 661.753.5400
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Patient Name: _____ Date of Birth: _____ Sex: Male / Female / Unknown

Weight: _____ Height: _____

Duration of Symptoms _____

What symptoms / problems are you currently having? _____

Have you had surgery / trauma in the area to be scanned? ☐ Yes ☐ No (if yes) When? _____

Do you have history of cancer? ☐ Yes ☐ No (if yes) Type? _____

Please indicate if you have the following:

Cardiac Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Loop recorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
Aneurysm clip	<input type="checkbox"/> Yes <input type="checkbox"/> No	Breast tissue expander (not implants)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Implanted drug infusion device	<input type="checkbox"/> Yes <input type="checkbox"/> No	Artificial limb	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bone growth stimulator	<input type="checkbox"/> Yes <input type="checkbox"/> No	Orthopedic items: pins, rods, screws, plates	<input type="checkbox"/> Yes <input type="checkbox"/> No
Neurostimulator	<input type="checkbox"/> Yes <input type="checkbox"/> No	Electrodes / Pacemaker wires	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any type of biostimulator	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cochlear implant / mid-ear implant	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any type of removable dental items	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gianturco coil (spring embolus coil)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hearing aid	<input type="checkbox"/> Yes <input type="checkbox"/> No	Intravascular filter / coil stent	<input type="checkbox"/> Yes <input type="checkbox"/> No
Claustrophobia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Any type of surgical clips or staples	<input type="checkbox"/> Yes <input type="checkbox"/> No
Previous metal in the eye	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you pregnant	<input type="checkbox"/> Yes <input type="checkbox"/> No
Shrapnel or bullet	<input type="checkbox"/> Yes <input type="checkbox"/> No	Penile prosthesis	<input type="checkbox"/> Yes <input type="checkbox"/> No
ICD - Defibrillator	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tattooed eyeliner / Tattoo	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Latex allergy	<input type="checkbox"/> Yes <input type="checkbox"/> No

MRI contrast history:

Have you ever had MRI contrast? ☐ Yes ☐ No

Did you ever have any kind of reaction? ☐ Yes ☐ No (if yes) explain? _____

PREGNANT PATIENTS: The safety of MRI screening during pregnancy has not been established. The decision to proceed will be on an individual basis, after considering the medical necessity and alternate imaging methods.

ATTENTION ALL PATIENTS: Please inform the technologist prior to your scan if you have any body or facial tattoos.

Do you accept the risk that you may experience skin swelling, irritation, or possible burn to the area?
If you have a problem or discomfort during the procedure, the test will be stopped.

I attest that the above information is correct to the best of my knowledge. I have read and understand the content of this form.

Patient Signature: _____ Date: _____