

# MRI PATIENT HISTORY AND SCREENING FORM

Patient Name: \_\_\_\_\_ Sex: M F Weight: \_\_\_\_\_ Ht: \_\_\_\_\_

Date: \_\_\_\_\_ D.O.B: \_\_\_\_\_ Age: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

Reason you are here today? Explain your medical problem in detail. (What is the problem? Where is the problem? Etc...)

\_\_\_\_\_

\_\_\_\_\_

---

Is your problem related to an injury?  Yes  No If yes, Date of injury? \_\_\_\_\_

How were you injured?  Work  Motor Vehicle Accident  Other

Have you taken any sedation/alcohol today to relax you for this procedure?  Yes  No If yes, what? \_\_\_\_\_

If yes, do you have someone to drive you home?  Yes  No

---

**Do you have or have you ever had any of the following?**

- Yes  No Cardiac Pacemaker: \_\_\_\_\_
- Yes  No Heart Surgery/Heart Valve: If Yes, explain: \_\_\_\_\_
- Yes  No Implanted Cardiac Defibrillator (ICD): \_\_\_\_\_
- Yes  No Brain Aneurysm Clips/ Brain Surgery: If Yes, explain: \_\_\_\_\_
- Yes  No Shunts/Stents/Filters/Intravascular Coil: \_\_\_\_\_
- Yes  No Eye Surgery/Implants/Spring/Wires/Retinal Tack: \_\_\_\_\_
- Yes  No Injury to the Eye Involving Metal or Metal Shavings: \_\_\_\_\_
- Yes  No Orthopedic Pins/Screws/Rods/Joints/Prosthesis: \_\_\_\_\_
- Yes  No Neurostimulator/Biostimulator: \_\_\_\_\_
- Yes  No History of Cancer or Tumors: When: \_\_\_\_\_ Where: \_\_\_\_\_
- Yes  No Radiation Therapy/Chemo Therapy: \_\_\_\_\_
- Yes  No Previous Back Surgery (Lumbar/Thoracic/Cervical): When: \_\_\_\_\_ Levels: \_\_\_\_\_
- Yes  No Ear Surgery/Cochlear Implants/Hearing Aids/Stapes Prosthesis: \_\_\_\_\_
- Yes  No Vascular Access Port/Catheter: \_\_\_\_\_
- Yes  No Metal Mesh Implants/Wire Sutures/Wire Staples or Clips/Internal Electrodes: \_\_\_\_\_
- Yes  No Electrical/Mechanical/Magnetic Implants? Type: \_\_\_\_\_
- Yes  No Implanted Drug Infusion Pump/Insulin Pump: \_\_\_\_\_
- Yes  No Are you Pregnant? When was your last Menstrual Period/Cycle? \_\_\_\_\_
- Yes  No Tattoo's/Permanent Make-up/Body Piercing/Patches: \_\_\_\_\_
- Yes  No Dentures/Partials/Dental Implants: \_\_\_\_\_
- Yes  No Gunshot Wounds/Shrapnel/BB: \_\_\_\_\_
- Yes  No Do you have pins in your Hair/Clothes/Hair Extensions/Hair Pieces/Wig: \_\_\_\_\_

List any Drug Allergies: \_\_\_\_\_

List Previous Surgeries: \_\_\_\_\_

List any Medications you're presently taking: \_\_\_\_\_

**MRI Contrast History:**

Not applicable to this exam

- Have you ever had MRI contrast?  Yes  No
- Did you have any kind of reaction?  Yes  No If yes, explain: \_\_\_\_\_
- Are you breast feeding at this time?  Yes  No
- \*\* Do you have any history of Renal disease?  Yes  No
- \*\* Do you have any history of Hypertension?  Yes  No
- \*\* Do you have any history of Diabetes?  Yes  No
- \*\* Have you ever had severe hepatic disease or liver transplant or pending liver transplant?  Yes  No

I attest that the above information is correct to the best of my knowledge. I have also informed the technologist that I am not pregnant at this time and I give consent to have a contrast agent administered to me if needed for proper diagnosis of my procedure. I acknowledge that I am aware of the possibility of side effects with contrast and I have had the opportunity to ask questions related to this form, to ask questions regarding the MRI procedure, and I understand the information presented to me.

X \_\_\_\_\_  
Patient/Parent/Legal Guardian MRI Technologist's Signature Date

\_\_\_\_\_  
Amount & Type of Contrast Lot Number Expiration Date