

# MRI HISTORY AND SCREENING FORM

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Sex: M F Height: \_\_\_\_\_ Weight: \_\_\_\_\_

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/Bio stimulator: \_\_\_\_\_

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: \_\_\_\_\_

If you wear Habitrol and/or Transderm Scop patches they must be removed before you enter the MRI room. No exceptions.

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**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

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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.

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

**FOR TECHNOLOGIST USE ONLY**

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Type of Contrast: \_\_\_\_\_ Contrast Temperature: \_\_\_\_\_

Lot Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Time of Injection: \_\_\_\_\_ Amount: \_\_\_\_\_