MRI Screening Form

Patient name ________________________________ DOB ____________ Date ______________________

Height __________ Weight ____________ F ◯ M ◯ Referring physician ___________________________

Please indicate if you have or had any of the following:

Yes ◯	◯ NO	**Pacemaker**
Yes ◯	◯ NO	**Heart Surgery/ Stents/Heart Valve replacement; Dates _____________**
Yes ◯	◯ NO	**Implanted cardiac defibrillator**
Yes ◯	◯ NO	**Brain aneurysm clip**
Yes ◯	◯ NO	**Brain surgery; Dates ________________**
Yes ◯	◯ NO	**Shunts/Intravascular coils (spinal or intraventricular)**
Yes ◯	◯ NO	**Neurostimulator/Bone growth stimulator**
Yes ◯	◯ NO	**Vascular access port**
Yes ◯	◯ NO	**Metal mesh implant/Wire sutures/wire staples/Internal electrodes**
Yes ◯	◯ NO	**ANY Electrical, mechanical or Magnetic implants (eye, penile etc.)**
Yes ◯	◯ NO	**Artificial or Prosthetic limb**
Yes ◯	◯ NO	**Orthopedic pins, screws, rods, etc.**
Yes ◯	◯ NO	**Tissue Expanders (Breast)**
Yes ◯	◯ NO	**Implanted drug infusion pump/Insulin pump**
Yes ◯	◯ NO	**Eyelid spring or wire**
Yes ◯	◯ NO	**Small bowel endoscopy capsule**
Yes ◯	◯ NO	**Cochlear implant, otologic or other ear implant**
Yes ◯	◯ NO	**Ear surgery**
Yes ◯	◯ NO	**Hearing aid**
Yes ◯	◯ NO	**Partials, dentures or braces**
Yes ◯	◯ NO	**Skin patches (nitroglycerine, stop-smoking patches etc.)**
Yes ◯	◯ NO	**Tattoo or permanent makeup**
Yes ◯	◯ NO	**Shrapnel or BB's**
Yes ◯	◯ NO	**Have you ever been a machinist, welder or had any metal removed from your eye**

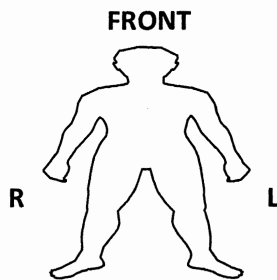
As part of your exam, the radiologist may deem it advisable to give you an IV injection of a contrast agent containing gadolinium. Although gadolinium contrast has been used safely in millions of cases, minor reactions (headache or nausea) occur in about 2% of patients. Serious or life-threatening reactions have been reported in about one in 400,000 patients.

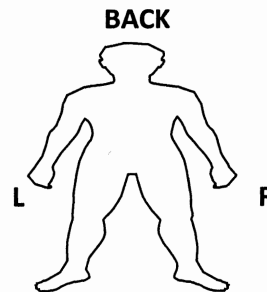
*Have you ever had an allergic reaction to Gadolinium contrast material? ◯ **YES** ◯ **NO**

Continued on back

Reason for exam/symptoms ____

Please mark the area of interest on body chart below





*Have you had **ANY** previous imaging related to this injury? XRAYS, MRI'S, CAT scans **YES** ○ **NO** ○

DATE ________________ TEST ___________________ WHERE _____________________

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*List ALL SURGERIES with Dates:

____

____

*List ALL ALLERIGES ____

*List ALL MEDICATIONS

____

***Have you ever had the following?**

○ YES ○ NO Chronic Kidney disease or Failure

○ YES ○ NO Diabetes

○ YES ○ NO High blood pressure

○ YES ○ NO Heart/Circulation disorders

○ YES ○ NO Stroke or TIA

○ YES ○ NO Seizures

○ YES ○ NO Cancer type ___________________________

○ YES ○ NO Recent vision trouble ○ Left ○ Right ○ Both

○ YES ○ NO Hearing trouble ○ Left ○ Right ○ Both

Female patients: Is there any possibility of pregnancy? YES ○ NO ○ Are you currently breast feeding ? YES ○ NO ○

Patient/Parent/Legal Guardian signature ____

Technologist signature ____

DATE___________________________