

## PATIENT HISTORY AND SCREENING FORM FOR MRI

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

DOB: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

**Clinical History:**

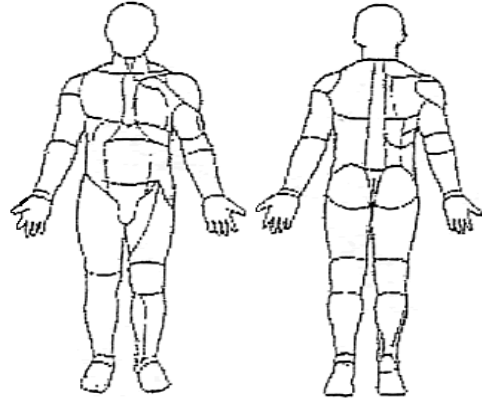
Please explain in your own words your medical problems that are the reason for your exam (MRI) today:

Have you had a previous X-ray, Ultrasound, MRI or CT Scan relating to this problem?  Yes  No

If Yes, what type of exam was done & name of the facility that performed the exam:

**DO YOU HAVE ANY OF THE FOLLOWING ITEMS IN YOUR BODY?**

- Pacemaker  Yes  No
- Ear/Cochlear Implant/Hearing Aid  Yes  No
- Brain/Aneurysm Clips  Yes  No
- Metal in eyes or ever had any removed  Yes  No
- Metal fragments or shrapnel  Yes  No
- Implanted electrical device  Yes  No
- Neurostimulators  Yes  No
- Stents  Yes  No
- Dentures held in with magnets  Yes  No
- Tattoos/Permanent Make-up  Yes  No
- Body piercing(s)  Yes  No
- Diabetes  Yes  No
- Kidney disease/single kidney/failure  Yes  No
- Liver transplant or failure  Yes  No
- Currently receiving dialysis/Blood Transfusion  Yes  No
- History of myeloma  Yes  No
- Any other metal objects or implants \_\_\_\_\_



PLEASE MARK AREA OF PAIN

List previous Surgeries: \_\_\_\_\_

**FOR SPINE EXAMS: ANY ARM OR LEG PAIN?**  Right  LEFT

Have you ever had an injection of contrast for an MRI?  Yes  No

- If yes, did you experience any of the following?
- Hives  Yes  No
  - Shortness of breath  Yes  No

Please list any other medical problems: \_\_\_\_\_

List all allergies: \_\_\_\_\_

**FEMALE PATIENTS:**

- Is there any possibility of pregnancy  Yes  No \_\_\_\_\_ Initials
- Are you currently breast-feeding  Yes  No

I have answered these questions to the best of my knowledge and understand the information that has been presented to me.

Patient/Parent/Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Technologist/Witness Signature \_\_\_\_\_ Technologist Notes: \_\_\_\_\_

NOT APPLICABLE TO THIS EXAM

\_\_\_\_\_ cc of \_\_\_\_\_  
*Amount                      Type of Contrast                      # of Punctures                      Lot #                      Expiration Date*

CONTRAST REACTION:  YES  NO Physician Covering Contrast: \_\_\_\_\_ Tech Initials: \_\_\_\_\_

**EXPLAIN:**