

MRI PATIENT HISTORY AND SCREENING FORM

Patient Name _____ SMIID# _____ Exam# _____

Pt. Height _____ Pt. weight _____ DOB _____ Sex M F

Reason you are here today? Please explain your medical problem in detail including how long you have had this problem.

Have you had a previous MRI exam related to this problem? Y N If yes when/where _____

Is your problem related to an injury? Y N Date of injury? _____ Type of injury? MVA Work Other

Do you have or have ever had any of the following? If yes please explain.

YES NO Heart surgery/ Heart valve/ Cardiac Pacemaker? _____

YES NO Brain Surgery /Brain aneurysm Clips? _____

YES NO Shunts/ Stents (ex: coronary)/ Intravascular Coil? _____

YES NO Implanted cardiac defibrillator, pacing leads or wires? _____

YES NO Any electrical, mechanical, or magnetic implants? Type. _____

YES NO Implanted drug infusion pump/ insulin pump? _____

YES NO Neurostimulator / Biostimulator/ internal electrodes: _____

YES NO Ear Surgery / Cochlear implant /Hearing Aids(please remove before exam) _____

YES NO Eye Surgery / Implants _____

YES NO Injury to eye involving metal or metal shavings(ex: from welding) _____

YES NO Orthopedic pins, screws, rods, etc. _____

YES NO Vascular access port? If yes type/ location: _____

YES NO Metal mesh Implants / Wire sutures/ Wire staples /internal electrodes: _____

YES NO Gunshot wounds, shrapnel, BB's. _____

YES NO Tattoo's / permanent make-up / body piercing. If yes location: _____

YES NO Dentures, partials, Braces, dental implants, or implant held in place by magnets. _____

YES NO History of Tumor / Cancer? Location; _____

YES NO Radiation / Chemotherapy? _____

YES NO Do you have pins in clothes(please remove)/ pins in hair, or hair extensions/ wig? _____

YES NO Pregnant or possibility of pregnancy / breast feeding

YES NO History of claustrophobia

YES NO History of (please circle) : **Kidney disease, Hypertension, Diabetic, Asthma**

List previous surgeries and approximate dates: _____

Please list any Drug / Medication Allergies: _____

Have you had MRI contrast? YES NO Did you have any type of reaction? YES NO

If yes please explain: _____

I certify that the above responses are correct to the best of my knowledge.

SIGNATURE:

DATE: _____

CONTRAST CONSENT: Your study may have been ordered by your physician to include an intravenous gadolinium injection, or our radiologist may feel that after reviewing your study and/or history you need to have an intravenous gadolinium injection, which will be performed by one of our certified technologists under the supervision of our ACLS certified technologist or radiologist. Please sign and date below.

SIGNATURE OF CONSENT:

DATE: _____

FOR OFFICE USE ONLY CONTRAST AMOUNT _____ ML CONTRAST LOT/EXP: _____ SITE: R/L _____ GAUGE

TECHNOLOGIST INITIALS _____