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MRI History and Screening Form

Appt Date ____ / ____ / ____ **Exam (1)** ____________________________ **Exam (2)** ____________________________

Patient Name: ______________________________ **MRN:** ______________ **Date of Birth:** ________________

Physician: ______________________________________ **Physician Phone #:** ______________________________

Sex: ☐ **Male** ☐ **Female Height:** ______ **Weight:** ______ **Previous Imaging related to current exam?** ☐ **Yes** ☐ **No** ***Bring CD*_____**

We know the paperwork is inconvenient, but it is necessary to ensure your safety.
Thank you for your assistance and understanding.

List All Previous Surgeries (use other side if necessary): ____

____

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

☐ Yes ☐ No Cardiac Pacemaker
☐ Yes ☐ No Implanted Cardiac Defibrillator (ICD)
☐ Yes ☐ No Ear Surgery/Cochlear Implants/Hearing Aids/Stapes Prosthesis: ______________________________
☐ Yes ☐ No Electrical/Mechanical/Magnetic Implants? Type: ______________________________________
☐ Yes ☐ No Neuro-Stimulator/Bio-Stimulator/Bone Growth Stimulator
☐ Yes ☐ No Eye Surgery/Implants/Spring/Wires/Retinal Tack
☐ Yes ☐ No Any Prosthesis/Implant: IUD, Diaphragm, Penile Implant or Pessary, etc… ____________________
☐ Yes ☐ No Implanted Drug Infusion Pump/Insulin Pump: ______________________________________
☐ Yes ☐ No Breast Tissue Expander
☐ Yes ☐ No Brain Aneurysm Clips/ Brain Surgery: If Yes, explain: ______________________________
☐ Yes ☐ No Injury to the Eye Involving Metal or Metal Shavings or Any Metal Injury to Your Body
☐ Yes ☐ No Heart Surgery/Heart Valve: If Yes, explain: ______________________________________
☐ Yes ☐ No Shunts/Stents/Filters/Intravascular Coil:
☐ Yes ☐ No Gunshot Wounds/Shrapnel/BB: ____
☐ Yes ☐ No Tattoo's/Permanent Make-up/Body Piercing/Patches
☐ Yes ☐ No Medication Patches: ____
☐ Yes ☐ No Previous Back Surgery (Lumbar/Thoracic/Cervical): When: ______________ Levels: ________________
☐ Yes ☐ No Vascular Access Port/Catheter
☐ Yes ☐ No Metal Mesh Implants/Wire Sutures/Wire Staples or Clips/Internal Electrodes
☐ Yes ☐ No Are you or could you be Pregnant? When was your last Menstrual Period/Cycle? ________________
☐ Yes ☐ No Dentures/Partials/Dental Implants
☐ Yes ☐ No Do you have pins in your Hair/Clothes/Hair Extensions/Hair Pieces/Wig
☐ Yes ☐ No Are you Claustrophobic? ☐ Yes ☐ No Do you need medication for Claustrophobia?
☐ Yes ☐ No Gastric Reflux Device: *LINX Reflux Management System*
☐ Yes ☐ No Are you taking any Medications, if yes please fill out Medication Reconciliation Form

MRI Contrast History: Have you ever had MRI contrast? ☐ Yes ☐ No
Did you have any kind of reaction? ☐ Yes ☐ No If yes, explain: ______________________________________
Do you have any history of Renal disease? ☐ Yes ☐ No Are you on Renal dialysis? ☐ Yes ☐ No
Do you have any history of Hypertension? ☐ Yes ☐ No Do you have any history of Diabetes? ☐ Yes ☐ No
eGFR: _____________ List any Allergies: ____

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.

Patient/Parent/Legal Guardian Signature ________________________________ **Date** ________________
Form Completed by: ☐ Patient ☐ Relative/Friend ☐ Nurse ☐ Clerical ☐ Technologist ☐ Physician

MRI Technologist's Signature: ______________________________________ **Date** ________________