



MRI PATIENT HISTORY AND SCREENING FORM

Patient Name: _____ Date: _____ Sex: M F Weight: _____ Ht: _____

MRN: _____ DOB: _____ Age: _____ Procedure: _____

Referring Physician: _____ Primary Physician: _____

Reason you are here today? Explain your medical problem in detail. (What is the problem? Where is the problem? Etc...)

Have you had previous exams related to your symptoms? Yes No
Where & When? _____

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

Yes No History of Cancer or Tumors: When: _____ Where: _____

Yes No History of Dialysis or Renal Insufficiency/Kidney Problems: _____

Yes No Do you take medications for high blood pressure: _____

Yes No Diabetic? _____

Yes No Smoker? _____

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 Radiation Therapy/Chemo Therapy: _____

Yes No Shunts/Stents/Filters/Intravascular Coil: _____

Yes No Eye Surgery/Implants/Spring/Wires/Retinal Tack: _____

Yes No Have you ever done any welding or grinding? _____

Yes No Injury to the Eye Involving Metal or Metal Shavings: _____

Yes No Orthopedic Pins/Screws/Rods/Joints/Prosthesis: _____

Yes No Neurostimulator/Biostimulator: _____

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 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 any allergies? If yes, list: _____ Sickle cell anemia? _____

Yes No Have you had any surgeries? If yes, list type and date of surgery: _____

Yes No Do you currently have a PillCam? _____

FEMALE HEALTH HISTORY

Yes No Are you Pregnant?

Yes No Are you breast feeding at this time?

When was your last Menstrual Period/Cycle? _____ Hysterectomy Tubal Ligation IUD

MRI Contrast History

Not applicable to this exam

Applicable to this exam (Complete Contrast Consent Form)