

# MRI Patient History and Screening Form

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

Weight: \_\_\_\_\_ Height: \_\_\_\_\_ D.O.B: \_\_\_\_\_ Age: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

Allergies: \_\_\_\_\_

Reason you are here today? Explain your medical problem in detail ~ such as ~ What and where is the problem and how long have you had it: \_\_\_\_\_

Yes  No Is your problem injury related. Injury Date: \_\_\_\_\_

How Injured:  MVA,  Work,  Other: \_\_\_\_\_

Yes  No Have you had a previous exam related to this problem? *If Yes*, explain: \_\_\_\_\_

Yes  No Have you taken any sedatives or alcohol today to relax you for this procedure? *If Yes*, what? \_\_\_\_\_  
*If yes*, Do you have someone to drive you home?  Yes  No \_\_\_\_\_

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

- Yes  No Shunts/Stents/Intravascular Coil
- Yes  No Eye Surgery/Implants
- Yes  No Orthopedic pins, screws, rods, Harrington Rod, etc.
- Yes  No Neurostimulator/Bio stimulator, Implanted cardiac defibrillator
- Yes  No Radiation Therapy/Chemo Therapy
- Yes  No Ear Surgery/Cochlear Implants/Hearing Aids
- Yes  No Vascular Access Port
- Yes  No Metal Mesh Implants/Wire sutures/wire staples/internal electrode
- Yes  No Implanted drug infusion pump/insulin pump
- Yes  No Tattoo's/Permanent make-up/Body Piercing
- Yes  No Dentures, partials or dental implants
- Yes  No Gunshot Wounds, shrapnel, BB's
- Yes  No Nicotine, Nitroglycerin or any other patch
- Yes  No Do you have pins in hair, hair extensions, hair pieces or a wig?
- Yes  No Do you have any safety pins in your clothes?
- Yes  No Any electrical, mechanical, or magnetic implants. *Type:* \_\_\_\_\_
- Yes  No Previous Back Surgery (Low Back or Cervical) *When:* \_\_\_\_\_ *Levels:* \_\_\_\_\_
- Yes  No History of Cancer or Tumors *When:* \_\_\_\_\_ *Where:* \_\_\_\_\_
- Yes  No Injury to the eye involving metal or metal shavings.  **Orbits reviewed by:** \_\_\_\_\_  
**OR** have you ever worked as metal grinder, welder, or in a foundry
- Yes  No Heart Surgery/Heart Valve/Pacemaker/Pacemaker wires. *If yes*, explain: \_\_\_\_\_
- Yes  No Brain Surgery/Brain Aneurysm Clips. *If yes*, explain: \_\_\_\_\_
- Yes  No **Do you have renal insufficiency/failure**

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

MRI Contrast History: \_\_\_\_\_  **Not applicable to this exam**

Yes  No Have you ever had MRI contrast? *If Yes*, did you have any kind of reaction?  Yes  No  
*If yes*, explain: \_\_\_\_\_

Yes  No Is there a possibility of pregnancy? LMP if applicable: \_\_\_\_\_

Yes  No Are you breast feeding?