Date: _____ **Patient ID: _____**

MRI HISTORY AND SCREENING FORM

Patient Name: _____DoB: _____ SS# : _____
Address: _____ City: _____ St:_____ Zip: _____
Home phone: _____ Cell _____
Emergency Contact Name: _____ Phone#: _____
Sex: M F Age: _____ Height: _____ Weight: _____
Body Part to be Examined: _____
Reason for MRI and/or symptoms: _____
Referring Physician: _____ Phone: _____
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 Claustrophobic? □ Yes □ No

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 Shunts/Stents/Filters/Intravascular Coil: _____
□ Yes □ No Eye Surgery/Implants/Spring/Wires/Retinal Tack: _____
□ 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 History of Cancer or Tumors: When: _____ Where: _____
□ Yes □ No Radiation Therapy/Chemo Therapy: _____
□ 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 Are you Pregnant? When was your last Menstrual Period/Cycle? _____
□ 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 pins in your Hair/Clothes/Hair Extensions/Hair Pieces/Wig: _____

List any Drug Allergies: _____
List Previous Surgeries: _____
List any Medications you're presently taking: _____

If you wear Habitrol and/or Transderm Scop patches they must be removed before you enter the MRI room.

MRI Contrast History: **□Not applicable to this exam**
Have you ever had MRI contrast? □ Yes □ No
Did you have any kind of reaction? □ Yes □ No If yes, explain: _____
Are you breast feeding at this time? □ Yes □ No
Do you have any history of Renal disease? □ Yes □ No
Do you have any history of Liver disease? □ Yes □ No
Do you have any history of Hypertension? □ Yes □ No
Do you have any history of Diabetes? □ Yes □ No
Have you ever had severe hepatic disease or liver transplant or pending liver transplant? □ Yes □ No

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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. I acknowledge that I am aware of the possibility of side effects with contrast and I have had the opportunity to ask questions related to this form, to ask questions regarding the MRI procedure, and I understand the information presented to me.

_____ _____ _____
Patient/Parent/Legal Guardian **MRI Technologist's Signature** **Date**

FOR TECHNOLOGIST USE ONLY

Type of Contrast: _____ Amount: _____
Lot Number: _____ Expiration Date: _____