MRI Patient History and Screening Printable Form

Patient Name: ______________________________ Date: ______________

Email: ______________________________

Date of Birth: ____________ Age: ______ Weight: ________ Height: ________ Sex: M / F

Are You Pregnant? Yes No N/A Are you Breast Feeding at this time? Yes No

Date of Last Menstrual Period: ______________

Reason you are here today? Explain your medical problem in detail. (What is the problem? Where is the problem? How long have you had this problem?)

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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? ______________ Do you have someone to drive you home? Yes No

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

Cardiac Pacemaker	Yes	No
Heart Surgery/Heart Valve	Yes	No
Implanted Cardiac Defibrillator (ICD)	Yes	No
Brain Aneurysm Clips/ Brain Surgery	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	Yes	No
Radiation Therapy/Chemo Therapy	Yes	No
Previous Back Surgery (Lumbar/Thoracic/Cervical)	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	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
Breast Tissue Expander (Implanted Soft Tissue Retractors)	Yes	No
Do you have pins in your Hair/Clothes/Hair Extensions/Hair Pieces/Wig	Yes	No
Are you wearing clothing/athletic wear that may contain metallic microfiber	Yes	No
Anemia\Sickle Cell	Yes	No

If yes to any of the above questions please explain: ______________________________

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Patient Name: ______________________________

List any Drug Allergies: ______________________________

List Previous Surgeries: ______________________________

List any Medications you're presently taking: ______________________________

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: ______________________________

Do you have any history of Renal 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? Yes No

Have you ever had a liver transplant or pending liver transplant? Yes No

If yes, explain: ______________________________

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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.

Would you like a copy of the MRI Contrast safety insert? Yes No

______________________________ ______________________________ ______________

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

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