MRI Screening Form

Date_____

Last Name _____ **First Name** _____

DOB_____ **Age**_____ **Height**_____ **Weight**_____ (lbs) **Male / Female**

Please describe your symptoms/injury or reason for procedure? _____

_____

How long have you had these symptoms? _____

MEDICAL HISTORY SCREENING - PLEASE ANSWER THE FOLLOWING(Yes or No)

Have you ever had small metal shavings imbedded into your eyes? □ Yes □ No

Do you have a Cardiac Pacemaker? □ Yes □ No

Bullets or Shrapnel	□ Yes □ No	Cochlear Implants/Hearing Aid	□ Yes □ No
Heart Surgery	□ Yes □ No	Removable Dentures/Partials	□ Yes □ No
Vascular Filter or Stint	□ Yes □ No	Cataracts or Eye Implants	□ Yes □ No
Aortic Clips	□ Yes □ No	Tattoo, permanent eye/lip liner	□ Yes □ No
Brain Surgery	□ Yes □ No	Piercings (other than ear)	□ Yes □ No
Aneurysm Clips	□ Yes □ No	IUD	□ Yes □ No
Body Part _____		Penile Implants	□ Yes □ No
Carotid Clips	□ Yes □ No	Medication/Heat Patch	□ Yes □ No
Neurostimulator/		Harrington Rods (Spinal Rod)	□ Yes □ No
Implanted Pump	□ Yes □ No	History of Cancer	□ Yes □ No
Tens Units(Nerve Stimulator)	□ Yes □ No	Respiratory Disorders	□ Yes □ No
History of Stroke	□ Yes □ No	Artificial Limbs/Replacements	□ Yes □ No
Date of Stroke _____		Body Part _____	
Sickle Cell Anaemia	□ Yes □ No	Any Chance of Pregnancy	□ Yes □ No
Diabetes	□ Yes □ No	Breast Feeding Patients	□ Yes □ No
Kidney Disease/Renal Failure	□ Yes □ No	***(if receiving IV contrast, refrain from feeding for 24hr***)	

Do you have any other metal / medical devices inside your body? □ Yes □ No

If Yes, please list: _____

PREVIOUS MEDICAL HISTORY:

Have you had any prior Surgeries? □ Yes □ No

If yes, please list date and type of Surgery_____

_____

Are you allergic to any type of food, medications or imaging contrast (dye) □ Yes □ No

If Yes, what Type? _____

I understand the information presented to me and have answered all the questions to the best of my knowledge.

_____ _____ _____

Signature of person providing information | Relationship to patient | Date

(For Imaging Personnel Only)

Technologist Comments: _____

_____

Technologist Signature_____ **Date:**_____

Contrast Admin: _____ **Amt:** _____ (cc) _____ **GFR:** _____**Creatine:** _____