

MAGNETIC RESONANCE (MR) PROCEDURE - HISTORY AND SCREENING FORM

Date ____/____/____

Patient ID # _____

Name: _____
Last First Middle

Age: _____ Weight: _____

Male Female Body Part(s) to be examined: _____

Reason for MRI and/or Symptoms: _____

How long have you had these symptoms: _____

Referring Physician: _____ Next Appointment Date: _____

1. Have you had prior surgery, a procedure of any kind or any type of trauma on the area being scanned today? No Yes
If yes, please indicate the date and type: (Include history of cancer, chemotherapy, radiation treatment)

Date ____/____/____ Type of procedure/Trauma _____

Date ____/____/____ Type of procedure/Trauma _____

Date ____/____/____ Type of procedure/Trauma _____

2. Have you had a prior diagnostic imaging study or exam on the area being scanned today (MRI, CT, Xray)? No Yes
If yes, please list:

	Body Part	Date	Facility
MRI:	_____	____/____/____	_____
CT/CAT Scan:	_____	____/____/____	_____
Xray:	_____	____/____/____	_____
Ultrasound:	_____	____/____/____	_____
Nuclear Medicine:	_____	____/____/____	_____
Other:	_____	____/____/____	_____

3. Have you experienced any problem related to a previous MRI examination or MR procedure? No Yes
If yes, please describe: _____

4. Have you had an injury to the eye involving a metallic object or fragment (e.g., metallic slivers, shavings, foreign body, etc.)? No Yes
If yes, please describe: _____

5. Have you ever been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel, etc.)? No Yes
If yes, please describe: _____

6. Are you currently taking or have you recently taken any medication to help you get through this exam? No Yes
If yes, please list: _____

7. Are you allergic to any medication? No Yes
If yes, please list: _____

8. Do you have a history of asthma, allergic reaction, respiratory disease, or reaction to a contrast medium or dye used for an MRI, CT, or X-ray examination? No Yes

9. Do you have any history of seizures? No Yes
If yes, please describe: _____

For female patients:

10. Are you pregnant or suspect that you could be pregnant? No Yes



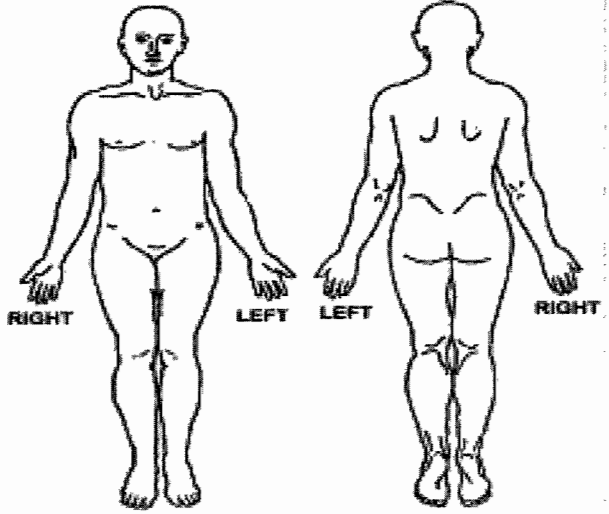
WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure (i.e., MRI, MR angiography, functional MRI, MR spectroscopy). **Do not enter** the MR system room or MR environment if you have any question or concern regarding an implant, device, or object. Consult the MRI Technologist or Radiologist **BEFORE** entering the MR system room. **The MR system magnet is ALWAYS on.**

Please complete backside of form

Please indicate if you have any of the following:

- Yes No Aneurysm clip(s)
- Yes No Cardiac pacemaker
- Yes No Implanted cardioverter defibrillator (ICD)
- Yes No Electronic implant or device
- Yes No Magnetically-activated implant or device
- Yes No Neurostimulation system
- Yes No Spinal cord stimulator
- Yes No Internal electrodes or wires
- Yes No Bone growth/bone fusion stimulator
- Yes No Cochlear, otologic, or other ear implant
- Yes No Insulin or other infusion pump
- Yes No Implanted drug infusion device
- Yes No Any type of prosthesis (eye, penile, etc.)
- Yes No Heart valve prosthesis
- Yes No Eyelid spring or wire
- Yes No Artificial or prosthetic limb
- Yes No Metallic stent, filter, or coil
- Yes No Shunt (spinal or intraventricular)
- Yes No Vascular access port and/or catheter
- Yes No Radiation seeds or implants
- Yes No Swan-Ganz or thermodilution catheter
- Yes No Medication patch (Nicotine, Nitroglycerine)
- Yes No Any metallic fragment or foreign body
- Yes No Wire mesh implant
- Yes No Tissue expander (e.g., breast)
- Yes No Surgical staples, clips, or metallic suture
- Yes No Joint Replacement (hip, knee, etc.)
- Yes No Bone/Joint pin,screw,nail,wire,plate, etc.
- Yes No IUD, Diaphragm or pessary
- Yes No Dentures or partial plates
- Yes No Tattoo or permanent makeup
- Yes No Body piercing jewelry
- Yes No Hearing aid (remove before entering MR room)
- Yes No Other Implant _____
- Yes No Breathing problem or motion disorder
- Yes No Claustrophobia
- Yes No Renal Failure / Dialysis / Kidney Disease

Please mark on the figure(s) below the location of any implant or metal inside of or on your body.



! IMPORTANT INSTRUCTIONS

Before entering the MR environment or MR system room, you must remove all metallic objects including: hearing aids, dentures, partial plates, keys, pagers, cell phone, eyeglasses, hair pins, barrettes, jewelry, body piercing jewelry, watch, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools, clothing with metal fasteners and clothing with metallic threads.

PLEASE consult the MRI Technologist or Radiologist if you have any questions or concerns BEFORE entering the MRI system room

I attest that the above information is correct to the best of my knowledge. I have read and I understand the contents of this form and I was given the opportunity to ask questions regarding the information on this form and regarding the MRI procedure that I am about to undergo.

Patient Signature: _____ Date ____/____/____

Signature of person completing form: _____ Date ____/____/____

Form completed by: Patient Relative Technologist _____ / _____
Print Name Relationship to Patient

Form reviewed by: _____
Print Name Signature

MRI Technologist Radiologist Other _____