

MRI PATIENT HISTORY AND SCREENING FORM

Patient Name: _____ Age: ___ Sex: M F Wt. _____ Ht _____

Reason for exam: _____

Is your problem related to an injury? If yes, explain _____

*** Are you pregnant? Y N Unsure ***Are you breastfeeding? Y N

Please answer the following questions

Y N Are you claustrophobic? If so, sedation may be required for a different day.

Y N Heart surgery/Heart valve replacement If yes, explain _____

Y N Pacemaker/Defibrillator (list manufacturer, present card) _____

Y N Brain surgery/ Aneurysm clips _____

Y N Stents/Shunt/Intravascular Coil _____

Y N Any firearms or knives on person _____

Y N Injury to eyes involving metal/ Eye surgery _____

Y N Orthopedic pins, rods or screws _____

Y N Neurostimulator / Tens unit _____

Y N Ear surgery / Cochlear implants _____

Y N Hearing Aids _____

Y N Mesh Implants / Wire sutures / Wire staples/ Internal electrode _____

Y N Implanted drug infusion pump/Glucose monitor _____

Y N Tattoo's/ Permanent makeup/Piercings _____

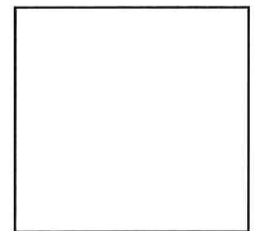
Y N BB's in the body / Shrapnel _____

Y N History of cancer or tumors? When _____ Type _____

Y N Previous back surgery C,T,L When _____ Level _____

Y N Any removable dental work? _____

MRI TECH



List surgeries not mentioned above: _____

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

Patient/Legal Guardian Signature

Date