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