



**MRI PROCEDURE SCREENING FORM FOR PATIENTS**

Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Patient Number: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Gender:  M  F Primary Care Phys: \_\_\_\_\_

Type of study to be performed: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

Symptoms: \_\_\_\_\_

1. Have you had prior surgery or an operation (e.g. arthroscopy, endoscopy, etc.) of any kind?  Yes  No

If yes, please indicate the date and type of surgery:

Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Type of Surgery \_\_\_\_\_

Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Type of Surgery \_\_\_\_\_

2. Have you had a prior diagnostic imaging study or examination relevant to the study you are having today?  Yes  No

If yes, please list:	Test	Date	Facility
_____	_____	_____/_____/____	_____
_____	_____	_____/_____/____	_____

3. Do you have a personal history of cancer?  Yes  No

If yes, what type? \_\_\_\_\_

4. Are you currently taking any medication? (Including medicated patches)  Yes  No

If yes, please list: \_\_\_\_\_

5. Are you allergic to any medication?  Yes  No

If yes, please list: \_\_\_\_\_

6. Are you pregnant, breastfeeding or suspect that you are pregnant?  Yes  No

LMP \_\_\_\_\_

**WARNING! Certain implants, devices or objects may be hazardous to you in the MRI room. DO NOT ENTER the MRI room without answering the following questions and discussing them with the technologist**

**Please indicate if you have any of the following:**

- Yes  No Aneurysm clip(s)
- Yes  No Cardiac pacemaker or Implanted cardioverter defibrillator (ICD)
- Yes  No Electronically or Magnetically activated implant or device
- Yes  No Neurostimulation or spinal cord stimulation system
- Yes  No Cochlear or implanted hearing aid
- Yes  No Insulin or implanted infusion pump
- Yes  No Any type of prosthesis, implant or prosthetic limb
- Yes  No Any metal fragment or foreign body (eyes or body)
- Yes  No IUD, diaphragm or pessary
- Yes  No Dentures or partial plates
- Yes  No Tattoo or permanent makeup
- Yes  No Hearing aid (**remove before entering the room**)
- Yes  No Other implant \_\_\_\_\_

**I attest the above information is correct to the best of my knowledge.**

Signature of person completing form: \_\_\_\_\_ Date \_\_\_\_\_

Form information reviewed by: \_\_\_\_\_  Technologist  Physician