MRI Patient History and Screening Printable Form

Patient Name: _____ Date: _____

Email: _____

Date of Birth: _____ Age: _____ Weight: _____ Height: _____ Sex: ○M / ○F

Are You Pregnant? ○Yes ○No ○N/A Are you Breast Feeding at this time? ◉Yes ○No

Date of Last Menstrual Period: _____

Reason you are here today? Explain your medical problem in detail. (What is the problem? Where is the problem? How long have you had this problem?)

_____

_____

Is your problem related to an injury? ○Yes ○No If yes, date of injury? _____

How were you injured? ☐Work ☐Motor Vehicle Accident ☑Other: _____

Have you taken any sedation/alcohol today to relax you for this procedure? ○Yes ○No

If yes, what? _____ Do you have someone to drive you home? ○Yes ○No

Do you have or have you ever had any of the following?

Cardiac Pacemaker	○Yes ○No
Heart Surgery/Heart Valve	○Yes ○No
Implanted Cardiac Defibrillator (ICD)	○Yes ○No
Brain Aneurysm Clips/ Brain Surgery	○Yes ○No
Shunts/Stents/Filters/Intravascular Coil	○Yes ○No
Eye Surgery/Implants/Spring/Wires/Retinal Tack	○Yes ○No
Injury to the Eye Involving Metal or Metal Shavings	○Yes ○No
Orthopedic Pins/Screws/Rods/Joints/Prosthesis	○Yes ○No
Neurostimulator/Biostimulator	○Yes ○No
History of Cancer or Tumors	○Yes ○No
Radiation Therapy/Chemo Therapy	○Yes ○No
Previous Back Surgery (Lumbar/Thoracic/Cervical)	○Yes ○No
Ear Surgery/Cochlear Implants/Hearing Aids/Stapes Prosthesis	○Yes ○No
Vascular Access Port/Catheter	○Yes ○No
Metal Mesh Implants/Wire Sutures/Wire Staples or Clips/Internal Electrodes	○Yes ○No
Electrical/Mechanical/Magnetic Implants	○Yes ○No
Implanted Drug Infusion Pump/Insulin Pump	○Yes ○No
Tattoo's/Permanent Make-up/Body Piercing/Patches	○Yes ○No
Dentures/Partials/Dental Implants	○Yes ○No
Gunshot Wounds/Shrapnel/BB	○Yes ○No
Breast Tissue Expander (Implanted Soft Tissue Retractors)	○Yes ○No
Do you have pins in your Hair/Clothes/Hair Extensions/Hair Pieces/Wig	○Yes ○No
Are you wearing clothing/athletic wear that may contain metallic microfiber	○Yes ○No
Anemia\Sickle Cell	○Yes ○No

If yes to any of the above questions please explain:_____

Patient Name: _____

List any Drug Allergies: _____

List Previous Surgeries: _____

List any Medications you're presently taking: _____

MRI Contrast History: ☐ Not applicable to this exam

Have you ever had MRI contrast? ◯Yes ◯No

Did you have any kind of reaction? ◯Yes ◯No

If yes, explain: _____

Do you have any history of Renal disease? ◯Yes ◯No

Do you have any history of Hypertension? ◯Yes ◯No

Do you have any history of Diabetes? ◯Yes ◯No

Have you ever had severe hepatic disease? ◯Yes ◯No

Have you ever had a liver transplant or pending liver transplant? ◯Yes ◯No

If yes, explain: _____

_____

I attest that the above information is correct to the best of my knowledge. I have also informed the technologist that I am not pregnant at this time and I give consent to have a contrast agent administered to me if needed for proper diagnosis of my procedure. I acknowledge that I am aware of the possibility of side effects with contrast and I have had the opportunity to ask questions related to this form, to ask questions regarding the MRI procedure, and I understand the information presented to me.

Would you like a copy of the MRI Contrast safety insert? ◯Yes ◯No

_____	_____	_____
Patient/Parent/Legal Guardian Signature	MRI Technologist's Signature	Date