MRI PATIENT HISTORY & SCREENING

Date: ______________________ **Height:** _________________ **Weight:** ____________________kg __________________ lb

Body part to be examined:____

Referring physician:______________________ **Reason for MRI and/or symptoms:**______________________

Patient has the following:

- ☐ braces
- ☐ body piercings
- ☐ claustrophobia
- ☐ dentures/partial plates
- ☐ hearing aids
- ☐ implants
  - ☐ aneurysm clips
  - ☐ bone growth stimulator
  - ☐ cardiac pacemaker/ICD
  - ☐ cochlear or other ear
  - ☐ drug infusion device
  - ☐ insulin pump
  - ☐ electrodes/wires
  - ☐ IUD/diaphragm
- ☐ magnetically-activated
- ☐ neurostimulation system
- ☐ penile
- ☐ radiation seeds
- ☐ spinal cord stimulator
- ☐ tissue expander
- ☐ vascular access port
- ☐ wire mesh
- ☐ medication patch
- ☐ metallic fragments (any)
- ☐ motion disorder
- ☐ prosthesis
  - ☐ bone/joint hardware
  - ☐ eyelid spring/wire
  - ☐ heart valve
  - ☐ joint replacement
  - ☐ prosthetic limb
- ☐ screw/pin/nail/plate
- ☐ shunt
- ☐ stent/filter/coil
- ☐ surgical staples/sutures
- ☐ Swan-Ganz
- ☐ tattoo/permanent makeup
- ☐ temperature probe
- ☐ thermodilution catheter

Date of stent:______________________

Heart valve model/number

____

Date of heart valve:

____

Allergy management: ☐ yes ☐ no	**Reaction to CT/MRI contrast:** ☐ yes ☐ no	**Endoscopy/Colonoscopy in last 3 months:** ☐ yes ☐ no

Urgent/Emergent care during this visit: ☐ yes ☐ no	**Radiation or chemotherapy:** ☐ yes ☐no

History of:

- ☐ anemia or blood disorder
- ☐ asthma or respiratory disease
- ☐ cancer
- ☐ diabetes
- ☐ high blood pressure
- ☐ liver disease
- ☐ renal disease
- ☐ renal failure
- ☐renal transplant
- ☐ seizures

Comments:

Any problems related to a previous MRI procedure: ☐ yes ☐ no	**Claustrophobia, anxiety, or emotional distress with MRI in the past:** ☐ yes ☐ no
Been injured by a metallic object or foreign body: ☐ yes ☐ no	**Any injury to the eye involving a metallic object:** ☐ yes ☐ no
Magnet on or in your body: ☐ yes ☐ no	**Currently pregnant:** ☐ yes ☐ no **If yes, number of weeks:** ________________
LMP: _____________ ☐ **Postmenopausal**	**Currently breastfeeding:** ☐ yes ☐ no

Notes:____

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Person completing form signature:______________________ **Date:** _____________ **Time:** _____________

Relationship to patient:______________________

Clinician signature:______________________ **Date:**_____________ **Time:** _____________

☐ **MRI Technologist** ☐ **Nurse** ☐ **Radiologist** ☐ **Other** ______________________

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