

**Patient History and Screening Form for MRI**

<b>Patient Name:</b>		<b>Phone #</b>	<b>HT</b>	<b>WT</b>
<b>DOB:</b>	<b>MRI Test:</b>	<b>MRI Date</b>		
<b>Diagnosis for MRI:</b>		<b>Referring Physician</b>		
<p>1. Have you ever had metal fragments in your eyes? YES NO</p> <p>2. Have you ever worked around metal (grinding or welding)? YES NO</p> <p style="text-align: center;">If the patient answered yes to either of the previous two questions, please arrange for an Orbit X-Ray before the MRI</p>				

**Do you have any of the following? If yes, please explain:**

- YES NO Heart Surgery/Heart Valve/Pacemaker: \_\_\_\_\_
- YES NO Shunts/Stents/Intravasclar Coil: \_\_\_\_\_
- YES NO Brain surgery/Brain Aneurysm Clips: \_\_\_\_\_
- YES NO Eye Surgery/Implants: \_\_\_\_\_
- YES NO Ear Surgery/Cochlear Implants/ Hearing aids: \_\_\_\_\_
- YES NO Orthopaedic pins, screws,rods,etc.: \_\_\_\_\_
- YES NO Neurostimulator/Biostimulator: \_\_\_\_\_
- YES NO Radiation Therapy/ Chemotherapy: \_\_\_\_\_
- YES NO History of Cancer/Tumors: \_\_\_\_\_
- YES NO Vascular Access Port: \_\_\_\_\_
- YES NO Previous surgery in the last six (6) weeks: \_\_\_\_\_
- YES NO Metal mesh implants/wire sutures/wire staples/internal Electrodes: \_\_\_\_\_
- YES NO Any electrical, mechanical or magnetic implants: \_\_\_\_\_
- YES NO Implanted drug infusion pump/insulin pump: \_\_\_\_\_
- YES NO Implanted cardiac defibrillator: \_\_\_\_\_
- YES NO Pacing wires, Swann GANZ catheter: \_\_\_\_\_
- YES NO Gunshot wounds,shrapnel, BB's: \_\_\_\_\_
- YES NO Tattoo's/ Permanent make-up, Body Piercings: \_\_\_\_\_
- YES NO Dentures, Partials or dental implants: \_\_\_\_\_
- YES NO Penile Prosthesis: \_\_\_\_\_
- YES NO History of any Kidney disease/ Impairment/ Surgery or Dialysis: \_\_\_\_\_
- YES NO Recent Lab Testing (BUN & Creatine): \_\_\_\_\_
- \*\* If yes, copy of recent labs required prior to MRI Contrast \*\***
- YES NO Have you had any surgery in lifetime? Please List: \_\_\_\_\_
- YES NO Have you ever has an MRI before? If yes, Where and when? \_\_\_\_\_

**Females Only:**

- YES NO Are you pregnant or breastfeeding? Last Menstrual Period: \_\_\_\_\_
- YES NO Any Breast Implant Spacers: \_\_\_\_\_
- YES NO Diaphragm/IUD/Pessary: \_\_\_\_\_

**List any Drug Allergies:** \_\_\_\_\_

**List any Current Medications:** \_\_\_\_\_

\*All piercings and medication patches need to be removed prior to exam

\* Any previous studies of area of today's exam? YES NO List: \_\_\_\_\_

**I have reviewed the above information; it is true to the best of my knowledge**

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Tech Signature: \_\_\_\_\_ Date: \_\_\_\_\_