## Patient History and Screening Form

**Patient Name:** ______________________________ **Sex:** M F **Weight:** _____ **Ht:** _____ **Referring Dr.** ________________

**Explain your symptoms / medical problem in *detail*. (What is the problem? Where is the problem? Etc...)**

______________________________________________________________________________

______________________________________________________________________________

**How long have you had these symptoms?** ______________________________________________

**Is your problem related to a work or auto injury?** Yes No **If yes, Date of injury?** ______________________

**How were you injured?** Work Motor Vehicle Accident Other

**Have you had any tests (MRI, CT, X-Ray, etc.) performed on body part we are scanning today?** Yes No

**If Yes, When** ________________ **Where** ______________________________________________

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

Yes No Cardiac Pacemaker: ______________________________________________
Yes No Heart Surgery/Heart Valve: If Yes, explain: ______________________________
Yes No Implanted Cardiac Defibrillator (ICD): ______________________________
Yes No Brain Aneurysm Clips/ Brain Surgery: If Yes, explain: ______________________
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: When: ________________ Where: ________________
Yes No Radiation Therapy/Chemo Therapy: ______________________________
Yes No Previous Back Surgery (Lumbar/Thoracic/Cervical): When: ________________ Levels: __________
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? Type: ______________________
Yes No Implanted Drug Infusion Pump/Insulin Pump: ______________________
Yes No Are you Pregnant? When was your last Menstrual Period/Cycle? ______________________
Yes No Tattoo's/Permanent Make-up/Body Piercing/Patches: ______________________
Yes No Dentures/Partials/Dental Implants: ______________________________
Yes No Gunshot Wounds/Shrapnel/BB: ______________________________
Yes No Do you have pins in your Hair/Clothes/Hair Extensions/Hair Pieces/Wig: ______________
Yes No Claustrophobia

**List any Drug/ Latex Allergies:** ______________________________________________

**List Previous Surgeries Pertinent to today's exam:** ______________________________

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**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
**Do you have any history of Renal disease? Yes No
** Do you have any history of Hypertension? Yes No
Are you breast feeding at this time? Yes No
** Do you have any history of Diabetes? Yes No If yes what meds are you taking? ______________________
**Have you ever had severe hepatic disease or liver transplant or pending liver transplant? Yes No

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I attest that the above information is correct to the best of my knowledge. 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 rare possibility of allergic reaction to contrast media (gadolinium) 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.

X______________________________ ______________________________ ______________________________
Patient/Parent/Legal Guardian Date MRI Technologist's Signature

______________________________ ______________________________ ______________________________
Amount & Type of Contrast Lot Number / Expiration Date Covering Radiologist