Physicians
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MRI PATIENT HISTORY AND SCREENING FORM

Name:_____ **Today's Date:**_____
Birth Date:_____ **Weight:**_____

The following items can *interfere* with MR Imaging and some may be hazardous to your safety.
Please **check** if you have any of the following items:

No	Yes	
_____	_____	Cardiac Pacemaker
_____	_____	Neurostimulator/Tens Unit
_____	_____	Aneurysm/Artery Clips/Shunts/Stents/IVC filters
_____	_____	Eye Surgery (Retinal Tract/Lens Implants)
_____	_____	Cochlear/Stapes Implant/Shunts (Ear implants)
_____	_____	Renal Insufficiency
_____	_____	Bone/Joint/Pins/Rods/Implants
_____	_____	IUD (intrauterine device)
_____	_____	Prosthesis (Artificial Limbs/Penile Implants/Etc.)
_____	_____	Implanted medication pumps (Insulin/Insulin pumps)
_____	_____	Any metal fragments/shrapnel/bullets?
_____	_____	Are you pregnant? How many weeks? _____
_____	_____	Are you breastfeeding?
_____	_____	Have you ever had metal removed from your eyes?
_____	_____	Do you wear hearing aids?
_____	_____	Do you have tattoos? Date:_____
_____	_____	Do you have any body piercings?
_____	_____	Do you have any removable dental work?
_____	_____	Do you have any blood disorders (sickle cell disease)?
_____	_____	Previous brain surgery Type:_____ Date:_____
_____	_____	Previous heart surgery Type:_____ Date:_____
_____	_____	Previous abdominal surgery Type:_____ Date:_____
_____	_____	Have you ever been diagnosed with any form of cancer?
		Type:_____ Date:_____
		Treatment given:_____

Have you ever had any X-rays/CT/MRI for *this* problem in the last 3 years?_____
If yes, what kind?_____ When:_____
Where? _____

Have you ever had an MRI done before? _____
If yes, what area of your body was scanned? _____
What facility was it done at?_____

- More information to be completed on back -

Is this exam being done due to a fall or an injury? _____ If yes, date of injury:_____
Is this a work related injury? _____
Explain what happened? _____
_____

Have you ever had surgery on the area being scanned today?_____
If yes, what type of surgery?_____
When? _____

Why are we doing this test today? (E.g. symptoms for doing the test)_____
_____

You only need to answer the section that pertains to the exam (body part) you are having today.

Brain (head, orbits, IACs, etc.)
Where is your pain?_____
Any numbness?_____ If yes, where?_____
Any visual disturbances (double/blurred vision)? _____
Any slurred speech?_____
Any hearing loss? _____ If yes, which ear?_____
Any memory loss? _____
History of having strokes? _____ If yes, when?_____
History of having seizures? _____ If yes, when? _____
Family history of aneurysms? _____ If yes, relationship? _____

Spine (cervical, thoracic, lumbar)
Where is your pain? _____
Any numbness? _____If yes, where? _____
Any previous back surgery?_____ If yes, when?_____
What disc levels?_____

Extremities (knees, shoulders, hips, ankles, etc.)
Where is your pain? _____
Any clicking or popping? _____
Does it ever lock up completely?_____
Any decrease in the range of motion? _____
Is this a sports injury? _____ If yes, explain?_____

Body (chest, abdomen, pelvis, etc.)
Where is your pain? _____
Any shortness of breath? _____
History of kidney stones? _____
Frequent urination? _____
Any diarrhea/constipation? _____

Patient Signature (or Guardian)_____ **Date**_____

Reviewed by (Technologist)_____ **Date**_____