

**MRI SCREENING FORM**

**Weight:** \_\_\_\_\_

**Reason for EXAM and/or symptoms:** \_\_\_\_\_

**Female Patients**

<b>Yes</b>	<b>No</b>	
<input type="checkbox"/>	<input type="checkbox"/>	Are you pregnant or suspect that you may be pregnant?

**All Patients**

<b>Yes</b>	<b>No</b>	
<input type="checkbox"/>	<input type="checkbox"/>	Is your problem a result of an injury? If yes, what was the date of injury: _____

<input type="checkbox"/>	<input type="checkbox"/>	Have you had surgery on the area we are imaging today? What kind? _____ If yes, what was the surgery date: _____
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<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had an injury to your eyes involving a metallic object of foreign body, such as metallic silver, shavings? Please describe: _____
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<input type="checkbox"/>	<input type="checkbox"/>	Do you have any personal history of cancer, or chemotherapy treatment? Explain: _____
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<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had heart surgery? Type: _____
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<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had brain surgery? Type: _____
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<input type="checkbox"/>	<input type="checkbox"/>	Do you have any diseases that affect your kidneys or blood?
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<input type="checkbox"/>	<input type="checkbox"/>	Are you Claustrophobic? If yes; are you premedicated? _____
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**Do you have any of the following?**

<b>Yes</b>	<b>No</b>	
<input type="checkbox"/>	<input type="checkbox"/>	Brain Stimulator (for Parkinson's)?
<input type="checkbox"/>	<input type="checkbox"/>	Electronic Implant or Device (e.g. Pacemaker)?
<input type="checkbox"/>	<input type="checkbox"/>	Magnetically Activated Implant or Device?
<input type="checkbox"/>	<input type="checkbox"/>	Implanted Drug Infusion Device?
<input type="checkbox"/>	<input type="checkbox"/>	Neurostimulator, Biostimulator, or Bone Growth Stimulator?
<input type="checkbox"/>	<input type="checkbox"/>	Eyelid Spring or wire?
<input type="checkbox"/>	<input type="checkbox"/>	Cochlear or Other Ear Implant?
<input type="checkbox"/>	<input type="checkbox"/>	Shrapnel, Bullet or Foreign Body?
<input type="checkbox"/>	<input type="checkbox"/>	Vascular Filter, Stent, or Coil?
<input type="checkbox"/>	<input type="checkbox"/>	Penile Implant?
<input type="checkbox"/>	<input type="checkbox"/>	Implanted Items held by a Magnet?
<input type="checkbox"/>	<input type="checkbox"/>	Recent Cortisone Injection? Date: _____

<b>Yes</b>	<b>No</b>	
<input type="checkbox"/>	<input type="checkbox"/>	Body Piercing Jewelry
<input type="checkbox"/>	<input type="checkbox"/>	Tattoo or Permanent Makeup?
<input type="checkbox"/>	<input type="checkbox"/>	Medication Patch?
<input type="checkbox"/>	<input type="checkbox"/>	Removable Dental Work?
<input type="checkbox"/>	<input type="checkbox"/>	Hearing Aids?

**For Technical Use Only:**

Injection Site: \_\_\_ LT AC \_\_\_ LT Hand  
 \_\_\_ RT AC \_\_\_ RT Hand  
 Other: \_\_\_\_\_  
 Injection Amount: \_\_\_\_\_ cc  
 Complete or attach contrast  
 Lot #: \_\_\_\_\_ Exp Date: \_\_\_\_\_

Patient: \_\_\_\_\_

Technologist: \_\_\_\_\_