MRI Patient History and Screening Form

Patient Name: _____

Date: _____

Email: _____

Phone: _____

DOB: _____

Height: _____

Weight: _____

Sex: M / F

Work Comp: Yes_____ No_____

MVA: Yes_____ No_____

Other (Please describe): _____

Date of Injury:_____

Comparisons: Yes_____ No_____ Date of Priors:_____

Reason you are here today. Please explain your medical problem in detail. (What is the problem, where is the problem located, length of time you have been experiencing this problem?)

_____
_____
_____

[Please continue to page 2 to complete]

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Have you taken any sedation/alcohol today in order to relax for your MRI? Yes / No

If yes, what did you take? _____

If yes, do you have someone to drive you after your MRI? Yes / No

The following items may be hazardous or may interfere with the MRI examination. Please indicate if you have or have ever had and of the following (circle Y or N):

Y / N Cardiac pacemaker
Y / N Implanted cardiac defibrillator
Y / N Aneurysm clip(s)
Y / N Carotid artery vascular clamp
Y / N Neurostimulator
Y / N Insulin or infusion pump
Y / N Implanted drug infusion device
Y / N Bone growth/fusion stimulator
Y / N Cochlear, otologic, or ear implant
Y / N Any type of prosthesis (eye, penile, etc.)
Y / N Artificial limb or joint
Y / N Electrodes (on body, head or brain)
Y / N Intravascular stents, filters or coils
Y / N Shunt (spinal or intraventricular)
Y / N Swan-Ganz catheter
Y / N Any implant held in place by a magnet
Y / N Transdermal delivery system (Nitro)
Y / N IUD or diaphragm
Y / N Tattooed makeup (eyeliner, lips, etc.)
Y / N Body piercing(s), (Remove before MRI)
Y / N Any metal fragments
Y / N Internal pacing wires
Y / N Metal or wire mesh implants
Y / N Hearing aid (Remove before MRI)
Y / N Dentures (Remove before MRI), braces, permanent retainers, or any other dental implant
Y / N Claustrophobia
Y / N Pregnancy or breastfeeding

[Please continue to page 3 to complete]

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If yes to any of the above questions, please explain:
_____
_____
_____

List any Drug Allergies: _____

List any Medications you are currently taking: _____
_____

List any previous surgeries with dates:
_____
_____
_____
_____

I attest that the above information is correct to the best of my knowledge. I have read and understand the entire contents of this form and I have had the opportunity to ask questions regarding the information on this form. I have also informed the technologist that I am not pregnant at this time.

_____
Patient/Parent/Legal Guardian Signature

_____
MRI Technologist's Signature

_____
Date