MAGNETIC RESONANCE (MR) PROCEDURE - HISTORY AND SCREENING FORM

Date _____/_____/_____ Patient ID #_____

Name:_____ Age:_____ Weight:_____
Last First Middle

Male ☐ Female ☐ Body Part(s) to be examined: _____

Reason for MRI and/or Symptoms: _____
_____

How long have you had these symptoms:_____

Referring Physician: _____ Next Appointment Date:_____

1. Have you had prior surgery, a procedure of any kind or any type of trauma on the area being scanned today? ☐ No ☐ Yes
   If yes, please indicate the date and type: (Include history of cancer, chemotherapy, radiation treatment)

   Date _____/_____/_____ Type of procedure/Trauma _____

   Date _____/_____/_____ Type of procedure/Trauma _____

   Date _____/_____/_____ Type of procedure/Trauma _____

2. Have you had a prior diagnostic imaging study or exam on the area being scanned today (MRI, CT, Xray)? ☐ No ☐ Yes
   If yes, please list:

	Body Part	Date	Facility
MRI:	_____	_____/_____/_____	_____
CT/CAT Scan:	_____	_____/_____/_____	_____
Xray:	_____	_____/_____/_____	_____
Ultrasound:	_____	_____/_____/_____	_____
Nuclear Medicine:	_____	_____/_____/_____	_____
Other:	_____	_____/_____/_____	_____

3. Have you experienced any problem related to a previous MRI examination or MR procedure? ☐ No ☐ Yes
   If yes, please describe: _____

4. Have you had an injury to the eye involving a metallic object or fragment (e.g., metallic slivers, shavings, foreign body, etc.)? ☐ No ☐ Yes
   If yes, please describe: _____

5. Have you ever been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel, etc.)? ☐ No ☐ Yes
   If yes, please describe: _____

6. Are you currently taking or have you recently taken any medication to help you get through this exam? ☐ No ☐ Yes
   If yes, please list:_____

7. Are you allergic to any medication? ☐ No ☐ Yes
   If yes, please list:_____

8. Do you have a history of asthma, allergic reaction, respiratory disease, or reaction to a contrast medium or dye used for an MRI, CT, or X-ray examination? ☐ No ☐ Yes

9. Do you have any history of seizures? ☐ No ☐ Yes
   If yes, please describe: _____

For female patients:

10. Are you pregnant or suspect that you could be pregnant? ☐ No ☐ Yes

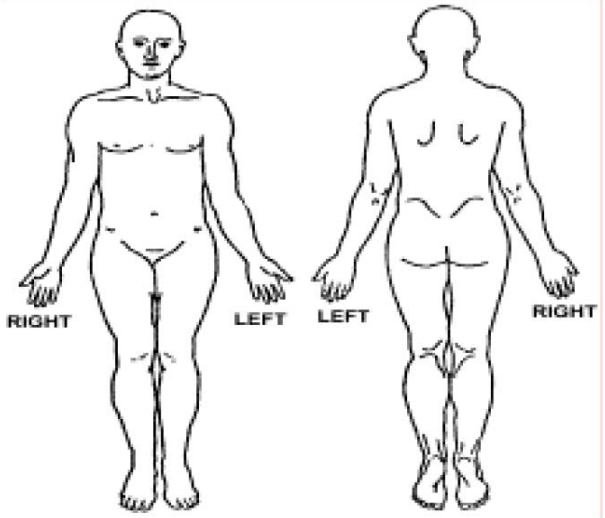
WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure (i.e., MRI, MR angiography, functional MRI, MR spectroscopy). **Do not enter** the MR system room or MR environment if you have any question or concern regarding an implant, device, or object. Consult the MRI Technologist or Radiologist BEFORE entering the MR system room. **The MR system magnet is ALWAYS on.**

Please complete backside of form

Please indicate if you have any of the following:

☐Yes ☐No Aneurysm clip(s)
☐Yes ☐No Cardiac pacemaker
☐Yes ☐No Implanted cardioverter defibrillator (ICD)
☐Yes ☐No Electronic implant or device
☐Yes ☐No Magnetically-activated implant or device
☐Yes ☐No Neurostimulation system
☐Yes ☐No Spinal cord stimulator
☐Yes ☐No Internal electrodes or wires
☐Yes ☐No Bone growth/bone fusion stimulator
☐Yes ☐No Cochlear, otologic, or other ear implant
☐Yes ☐No Insulin or other infusion pump
☐Yes ☐No Implanted drug infusion device
☐Yes ☐No Any type of prosthesis (eye, penile, etc.)
☐Yes ☐No Heart valve prosthesis
☐Yes ☐No Eyelid spring or wire
☐Yes ☐No Artificial or prosthetic limb
☐Yes ☐No Metallic stent, filter, or coil
☐Yes ☐No Shunt (spinal or intraventricular)
☐Yes ☐No Vascular access port and/or catheter
☐Yes ☐No Radiation seeds or implants
☐Yes ☐No Swan-Ganz or thermodilution catheter
☐Yes ☐No Medication patch (Nicotine, Nitroglycerine)
☐Yes ☐No Any metallic fragment or foreign body
☐Yes ☐No Wire mesh implant
☐Yes ☐No Tissue expander (e.g., breast)
☐Yes ☐No Surgical staples, clips, or metallic suture
☐Yes ☐No Joint Replacement (hip, knee, etc.)
☐Yes ☐No Bone/Joint pin, screw, nail, wire, plate, etc.
☐Yes ☐No IUD, Diaphram or pessary
☐Yes ☐No Dentures or partial plates
☐Yes ☐No Tattoo or permanent makeup
☐Yes ☐No Body piercing jewelry
☐Yes ☐No Hearing aid (remove before entering MR room)
☐Yes ☐No Other Implant _____
☐Yes ☐No Breathing problem or motion disorder
☐Yes ☐No Claustrophobia
☐Yes ☐No Renal Failure / Dialysis / Kidney Disease

Please mark on the figure(s) below the location of any implant or metal inside of or on your body.



⚠ IMPORTANT INSTRUCTIONS

Before entering the MR environment or MR system room, you must remove all metallic objects including: hearing aids, dentures, partial plates, keys, pagers, cell phone, eyeglasses, hair pins, barrettes, jewelry, body piercing jewelry, watch, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools, clothing with metal fasteners and clothing with metallic threads.

PLEASE consult the MRI Technologist or Radiologist if you have any questions or concerns BEFORE entering the MRI system room

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I attest that the above information is correct to the best of my knowledge. I have read and I understand the contents of this form and I was given the opportunity to ask questions regarding the information on this form and regarding the MRI procedure that I am about to undergo.

Patient Signature: _____Date _____/_____/_____

Signature of person completing form: _____Date _____/_____/_____

Form completed by: ☐ Patient ☐ Relative ☐ Technologist _____/_____
Print Name Relationship to Patient

Form reviewed by:_____ _____
Print Name Signature

☐ MRI Technologist ☐ Radiologist ☐ Other _____