PATIENT HISTORY AND MRI SAFETY SCREENING

FOR OFFICE USE ONLY

PATIENT# _____

D.O.B. _____

PLEASE PRINT

NAME: _____ AGE: _____ SEX: _____ WEIGHT: _____

PLEASE PRINT

NAME OF THE PHYSICIAN WHO REFERRED YOU FOR MRI: _____

WHAT REASON OR SYMPTOMS LEAD YOU TO SEEK MEDICAL HELP? _____

_____

HOW LONG HAVE YOU HAD THESE SYMPTOMS? _____

The following items can interfere with the Magnetic Resonance Imaging and some may be hazardous to your safety. Please indicate with a check mark if you do or do not have any of the following:

- CARDIAC PACEMAKER _____YES _____ NO
- ARTIFICIAL HEART VALVE _____YES _____ NO
- BIO OR NEUROSTIMULATOR _____YES _____ NO
- COCHLEAR IMPLANTS (EAR) _____YES _____ NO
- CLAUSTROPHOBIA _____YES _____ NO
- METALLIC IMPLANTS _____YES _____ NO
- HISTORY OF METAL WORKING _____YES _____ NO
  IF YES, SPECIFY_____
- ANY METAL IN YOUR BODY BY OPERATION OR ACCIDENT? _____YES _____ NO
  LIST: _____
- ANY METAL OR LENS IMPLANTS IN YOUR EYES BY OPERATION OR ACCIDENT? _____YES _____ NO
  LIST: _____
- SURGICAL CLIPS _____YES _____ NO
- BRAIN ANEURYSM CLIPS _____YES _____ NO
- SPINE OR BACK SURGERY _____YES _____ NO
- ANY OTHER SURGERY _____YES _____ NO
  LIST TYPES AND DATES: _____
  _____
- HISTORY OF CANCER _____YES _____ NO
- RENAL FAILURE _____YES _____ NO
- MEDICATION PATCHES, BANDAGES_____YES _____ NO
- TATTOO _____YES _____ NO
- ARE YOU PREGNANT NOW _____YES _____ NO
- PERMANENT MAKEUP _____YES _____ NO
- ANY KNOWN ALLERGIES _____YES _____ NO
  LIST:_____

HAVE YOU HAD A PREVIOUS MRI?

_____YES _____ NO, WHEN?_____ WHERE? _____

HAVE YOU HAD A PREVIOUS CT SCAN?

_____YES _____ NO, WHEN?_____ WHERE? _____

HAVE YOU HAD A MYELOGRAM?

_____YES _____ NO, WHEN?_____ WHERE? _____

WHAT WERE THE RESULTS OF THE ABOVE TESTS? _____

_____

Please sign below, indicating that you have understood and answered all the above questions.

SIGNED_____ RELATION _____

DATE _____ WITNESS _____