MRI SCREENING

DATE:_____ NAME:_____ DOB:_____ AGE:_____ WEIGHT:_____ HEIGHT:_____

1. Have you had any surgery other than dental surgery? If Yes, then please detail the date and type of surgery: ___
_____
2. Have you had any previous MR or CT or other recent x-ray studies? If YES, then please detail the date and type of study:
_____
3. Do you have a history of sickle cell anemia? O Yes O No
4. Have you ever worked in a machine shop or similar environment where you may have been subject to small metal slivers? O Yes O No
5. Is there a chance that you may be pregnant? O Yes O No

6. Date of last menstrual period? _____
Other comments: _____

Please indicate if you have any of the following:

⚠ IMPORTANT INSTRUCTIONS

Before entering the MR environment or MR system room, you must remove <u>all</u> metallic objects including hearing aids, dentures, partial plates, keys, beeper, 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, & clothing with metallic threads.

Please consult the MRI Technologist or Radiologist if you have any question or concern BEFORE you enter the MR system room. Please check Y for 'Yes, you have them' and N for 'No, you do not have them' for the following items:

Y	N	Aneurysm clip(s)	Y	N	Heart valve prosthesis	Y	N	Surgical staples, clips, or metallic sutures
Y	N	Cardiac pacemaker	Y	N	Eyelid spring or wire	Y	N	Joint replacement (hip, knee, etc.)
Y	N	Implanted cardioverter defibrillator (ICD)	Y	N	Artificial or prosthetic limb	Y	N	Bone/joint pin, screw, nail, wire, plate, etc.
Y	N	Electronic implant or device	Y	N	Metallic stent, filter, or coil	Y	N	IUD, diaphragm, or pessary
Y	N	Magnetically-activated implant or device	Y	N	Shunt (spinal or intraventricular)	Y	N	Dentures or partial plates
Y	N	Neurostimulation system	Y	N	Vascular access port and/or catheter	Y	N	Tattoo or permanent makeup
Y	N	Spinal cord stimulator	Y	N	Radiation seeds or implants	Y	N	Body piercing jewelry
Y	N	Internal electrodes or wires	Y	N	Swan-Ganz or thermodilution catheter	Y	N	Hearing aid
Y	N	Bone growth/bone fusion stimulator	Y	N	Medication patch (Nicotine,			*(Remove before entering MR system room)*
Y	N	Cochlear, otologic, or other ear implant			Nitroglycerine)	Y	N	Other implant
Y	N	Insulin or other infusion pump	Y	N	Any metallic fragment or foreign body	Y	N	Breathing problem or motion disorder
Y	N	Implanted drug infusion device	Y	N	Wire mesh implant	Y	N	Claustrophobia
Y	N	Any type of prosthesis (eye, penile, etc.)	Y	N	Tissue expander (e.g., breast)			

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

PATIENT SIGNATURE:_____ OFFICE USE: TECH_____

Marine Park Radiology, P.C.

2270 Kimball Street, #102
Brooklyn, New York 11234
Tel: 718-253-6616
Fax: 718-253-7059

HAROLD TANENBAUM, M.D., M.B.A.
RICHARD STEINBERG, M.D.
CERTIFIED AMERICAN BOARD OF RADIOLOGY
MEMBER OF AMERICAN COLLEGE OF RADIOLOGY

EMAIL: MARINEPARKRAD@OPTIMUM.NET
WEBSITE: WWW.MARINEPARKRADIOLOGY.NET

MRI Body Questionnaire

Name: _____ Date: _____

Age: _____ DOB: _____ Weight: _____ Height:_____

1. Is there any chance that you may be pregnant? ☐ Yes ☐ No

2. What was your chief complaint when you visited your doctor?

_____

3. Any pain/numbness or weakness at the present time? ☐ Yes ☐ No

If yes, please list: _____

4. Have you had any Chest/Abdominal or Pelvic Surgery? ☐ Yes ☐ No

If yes, please list: _____

5. Any recent injury to the chest/abdomen or pelvis? ☐ Yes ☐ No

If yes, please describe: _____

6. Do you have any personal or family history of cancer? ☐ Yes ☐ No

If yes, who and what type? _____

7. Any previous examples in this area? ☐ Yes ☐ No

If yes,, what kind and what was the result?: _____

8. Have you ever had an x-ray exam requiring an injection? ☐ Yes ☐ No

If yes, did you have any reaction to this injection? ☐ Yes ☐ No

9. Do you have any other medical conditions? ☐ Yes ☐ No

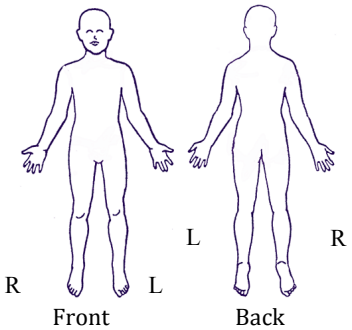
If yes, please describe: _____

10, Please list any allergies you may have: _____

11. Can you eat seafood and shellfish? ☐ Yes ☐ No

12. Describe your general health: _____

13. If you are female, date of last menstrual period: _____



Please shade areas that are painful