

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 all 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, Nitroglycerine)	Y	N	<i>(Remove before entering MR system room)</i>
Y	N	Cochlear, otologic, or other ear implant	Y	N	Any metallic fragment or foreign body	Y	N	Other implant
Y	N	Insulin or other infusion pump	Y	N	Wire mesh implant	Y	N	Breathing problem or motion disorder
Y	N	Implanted drug infusion device	Y	N	Tissue expander (e.g., breast)	Y	N	Claustrophobia
Y	N	Any type of prosthesis (eye, penile, etc.)						

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 _____

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MRI HEAD/BRAIN/IAC 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. Has there been any injury to the head? YES NO

If yes, when and please describe: _____

Any surgery in the head region? YES NO

If yes, when and please describe: _____

Any previous exams in this area? YES NO

If yes, when and please describe: _____

4. History of or headaches at the present time? YES NO

If yes, where: _____

5. Do you have dizziness or nausea? YES NO

6. Do you have hearing loss? YES NO

Right _____ Left _____ Both _____

7. Any weakness/numbness of arms or legs? YES NO

If yes, which side and when did it begin? _____ Has it improved? YES NO

8. Any loss of vision? YES NO

Right _____ Left _____ Both _____

9. Any recent loss of consciousness? YES NO

10. Please list all medications that you are currently taking: _____

11. Please list any allergies that you may have: _____

12. Are you currently smoking? _____ If not, history of smoking? _____

