

# MAGNETIC RESONANCE (MR) PROCEDURE - HISTORY AND SCREENING FORM

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient ID # \_\_\_\_\_

Name: \_\_\_\_\_  
Last                      First                      Middle

Age: \_\_\_\_\_ Weight: \_\_\_\_\_

Male  Female  Body Part(s) to be examined: \_\_\_\_\_

Reason for MRI and/or 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:

	<u>Body Part</u>	<u>Date</u>	<u>Facility</u>
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 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

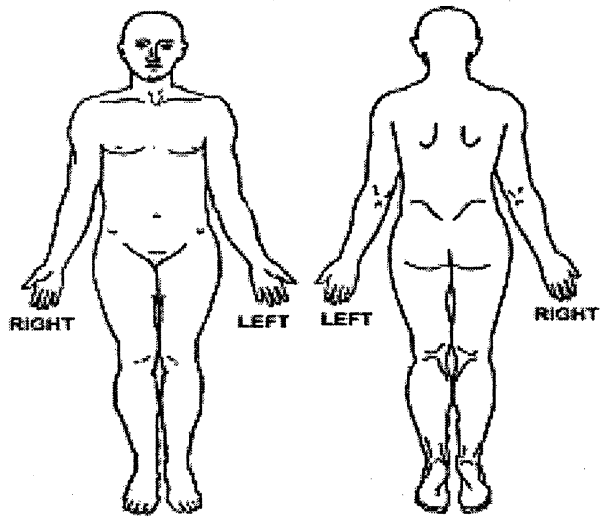


**WARNING:** Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure (i.e., MRI, MR angiography, functional MRI, MR spectroscopy). **Do not enter** the MR system room or MR environment if you have any question or concern regarding an implant, device, or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

**Please 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, Diaphragm 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

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

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 \_\_\_\_\_