MRI Screening History and Questionnaire Form

MRN: ___________

Date: ___ /___ /____

Name: ____ **Age:** _____ **Height:** _____ **Weight:** ______

Date of Birth: ___ /___ /____ [ ] **Male** [ ] **Female**

Reason for MRI and/or Symptoms: ____

Referring Physician: ____

1. Have you had prior surgery or an operation (e.g., arthroscopy, endoscopy, etc.) of any kind? [ ] Yes [ ] No
   If YES, please indicate the date and type of surgery:
   Date ___ /___/___ Type of surgery____
   Date ___ /___/___ Type of surgery____
2. Have you had a prior diagnostic imaging study or examination (MRI, CT, Ultrasound, X-ray, etc.)? [ ] Yes [ ] No
   Have you ever received a contrast agent/X-ray dye used for MRI, CT, or other X-ray or Study? [ ] Yes [ ] No
   Have you ever had an X-ray or Magnetic Resonance Imaging (MRI) contrast agent allergic reaction? [ ] Yes [ ] No
   If YES, please describe____
3. Have you experienced any problems related to a previous MRI examination or MR procedure? [ ] Yes [ ] No
   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.)? [ ] Yes [ ] No
   If YES, please describe____
5. Have you ever been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel, etc.)? [ ] Yes [ ] No
   If YES, please describe____
6. Have you ever done: Welding? Grinding? Machine Work? Metal Lathe Work? [ ] Yes [ ] No
   If YES, please specify____
7. Are you currently taking or have you recently taken any medications or drugs? [ ] Yes [ ] No
   If YES, please list____
8. Are you allergic to any medications? [ ] Yes [ ] No
   If YES, please list____
9. 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? [ ] Yes [ ] No
10. Do you have anemia or any disease(s) that affects your blood, a history of renal (kidney) disease, or seizures? [ ] Yes [ ] No
    If YES, please describe____

For Female Patients:

11. Are you pregnant or experiencing a late menstrual period? [ ] Yes [ ] No
    Date of last menstrual period ___ /___ /____ Post-menopausal? [ ] Yes [ ] No
12. Are you taking oral contraceptives or receiving hormonal treatment? [ ] Yes [ ] No
13. Are you taking any type of fertility medication or having fertility treatments? [ ] Yes [ ] No
    If YES, please describe____

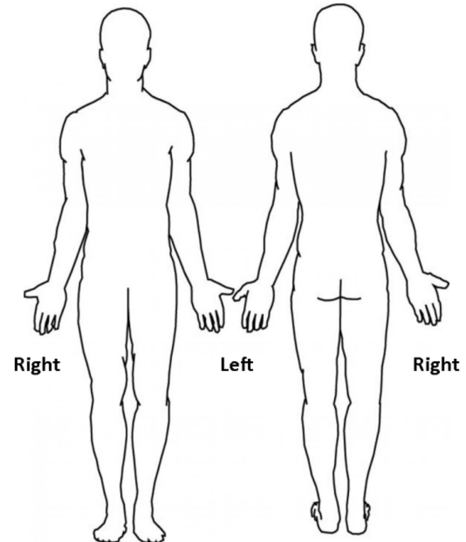
14. Are you currently breastfeeding? [ ] Yes [ ] No

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 questions or concerns 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 Claustrophobia
[ ] 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 Sutures
[ ] 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(s) or Permanent Makeup
[ ] Yes [ ] No Body Piercing Jewelry
[ ] Yes [ ] No Hearing Aid (Remove before entering MR System Room)
[ ] Yes [ ] No Other Implant: ___________________________
[ ] Yes [ ] No Breathing Problem or Motion Disorder
[ ] Yes [ ] No Biostimulator (Type: ______________________)
[ ] Yes [ ] No Halo Vest
[ ] Yes [ ] No Spinal Fixation Device
[ ] Yes [ ] No Spinal Fusion Procedure
[ ] Yes [ ] No Wig, Hair Implants
[ ] Yes [ ] No Any Hair Accessories (e.g. Bobby Pins, Barrettes, Clips)

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



<u>Important Instructions</u>

Before entering the MR environment or MR system room, you must remove all metallic objects including hearing aids, dentures, partial plates, keys, cell phones, eyeglasses, hair pins, barrettes, jewelry, body piercing jewelry, watches, safety pins, paperclips, money clips, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knives, nail clippers, 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 you enter the MR system room.

Note: You may be advised or required to wear ear plugs or other hearing protection during the MR procedure to prevent possible problems or hazards related to acoustic noise.

I attest that the 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 about the information on this form and regarding the MR procedure that I am about to undergo.

Signature of Person Completing Form: ____ Date: ________________________

RT/LPN Signature: ____________________________________ Print Name of RT/LPN: ____________________________________