



MRI Patient History and Screening Form

Patient Name: _____

Date: _____

Email: _____

Phone: _____

DOB: _____

Height: _____

Weight: _____

Sex: M / F

Reason you are here today. Please explain your medical problem in detail. (What is the problem, where is the problem located, length of time you have been experiencing this problem?)

Have you taken any sedation/alcohol today in order to relax for your MRI? Yes / No

If yes, what did you take? _____

If yes, do you have someone to drive you after your MRI? Yes / No

The following items may be hazardous or may interfere with the MRI examination. Please indicate if you have or have ever had and of the following (circle Y or N):

- Y / N Cardiac pacemaker
- Y / N Implanted cardiac defibrillator
- Y / N Aneurysm clip(s)
- Y / N Carotid artery vascular clamp
- Y / N Neurostimulator
- Y / N Insulin or infusion pump
- Y / N Implanted drug infusion device

[Please continue to page 2 to complete]



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- Y / N Bone growth/fusion stimulator
- Y / N Cochlear, otologic, or ear implant
- Y / N Any type of prosthesis (eye, penile, etc.)
- Y / N Artificial limb or joint
- Y / N Electrodes (on body, head or brain)
- Y / N Intravascular stents, filters or coils
- Y / N Shunt (spinal or intraventricular)
- Y / N Swan-Ganz catheter
- Y / N Any implant held in place by a magnet
- Y / N Transdermal delivery system (Nitro)
- Y / N IUD or diaphragm
- Y / N Tattooed makeup (eyeliner, lips, etc.)
- Y / N Body piercing(s), (Remove before MRI)
- Y / N Any metal fragments
- Y / N Internal pacing wires
- Y / N Metal or wire mesh implants
- Y / N Hearing aid (Remove before MRI)
- Y / N Dentures (Remove before MRI), braces, permanent retainers, or any other dental implant
- Y / N Claustrophobia
- Y / N Pregnant or breastfeeding

If yes to any of the above questions, please explain:

List any Drug Allergies: _____

List any Medications you are currently taking: _____

List any previous surgeries with dates:

[Please continue to page 3 to complete]



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MRI Contrast History: (Please Circle N/A if not applicable to your exam) N/A

If you are having an MRI with contrast, please answer the following questions:

Y / N Have you ever had MRI Contrast?

Y / N Did you have any kind of reaction?

If yes, explain:

Y / N Do you have any history of renal disease?

Y / N Do you have any history of Hypertension?

Y / N Do you have any history of Diabetes?

Y / N Have you ever had severe hepatic disease?

Y / N Have you ever had a liver transplant or pending liver transplant?

If yes, explain:

I attest that the above information is correct to the best of my knowledge. I have also informed the technologist that I am not pregnant at this time and I give consent to have a contrast agent administered to me if needed for proper diagnosis of my procedure. I acknowledge that I am aware of the possibility of side effects with contrast and I have had the opportunity to ask questions related to this form, to ask questions regarding the MRI procedure, and I understand the information presented to me

Patient/Parent/Legal Guardian Signature

MRI Technologist's Signature

Date