Advanced Imaging MRI Screening and History Form

Patients Name: _____ DOB: _____

Height: _____ Weight: _____lbs

Main symptoms/reason you are having your MRI today.

_____

Before you can have your MRI, we must know if you have had or do have any of the following:

Cardiac Pacemaker or Internal Defibrillator	**Yes ____**	**No ____**
Brain Aneurysm Clip	**Yes ____**	**No ____**
Have you had any surgery on your Brain?	**Yes ____**	**No ____**
If yes, what type? _____	**Date of surgery. _____**	
Implanted Nerve Stimulator	**Yes ____**	**No ____**
Cochlear or Stapes Ear Implant	**Yes ____**	**No ____**
Insulin Pump with Electrodes	**Yes ____**	**No ____**
Carotid Artery Vascular Clamp	**Yes ____**	**No ____**
Drug Infusion Pump	Yes ____	No ____
Heart Surgery, Heart valve replacement or Stents.	Yes ____	No ____
Programmable Brain Shunt	Yes ____	No ____
Any Implants such as: Orthopedic pins, Rods or Artificial Limbs.	Yes ____	No ____
If yes, Where? _____		
Previous work with metal or ever had a piece of metal in your eye?	Yes ____	No ____
Hearing Aids or Dentures.	Yes ____	No ____

Personal History:

Are you claustrophobic?	Yes ____	No ____
Do you have a history of Kidney disease or Renal failure?	Yes ____	No ____
Are you Diabetic?	Yes ____	No ____
Date of your last Laboratory work _____ Where? _____		
Have you ever been diagnosed with Cancer?	Yes ____	No ____
If yes, what type? _____		
If you are female, are you now pregnant or breastfeeding?	Yes ____	No ____

List any surgeries and dates (related to the body area being scanned today)

_____

List most recent studies of **area being scanned today** that would be helpful. Give dates and where it was done.

MRI _____

Cat Scan _____

Nuclear Bone Scan _____

I attest that the above information is correct to the best of my knowledge. I have had the opportunity to ask any questions regarding the information on this form.

Patient or Guardian Signature:

_____ Date: _____

Tech Notes:

Amount of Contrast: _____ Number of Attempts: _____ IV Site _____

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