{ MRI SCREENING FORM }

Name: _____Age:_____DOB:_____Weight:_____
Exam:_____ Reason for Exam:_____
Physician:_____ History of:_____

***Are you PREGNANT?** **YES** **NO**
***Are you CLAUSTROPHOBIC?** **YES** **NO**

****Please check (✓) if you have any of the following in or on your body ?**

	YES	NO
***Pacemaker (Cardiac)**	_____	_____
***Aneurysm Clips**	_____	_____
***Carotid Clips**	_____	_____
***Neurostimulator**	_____	_____
***Vena Cava Umbrella**	_____	_____
***Artificial Heart Valve**	_____	_____
Insulin Pump	_____	_____
Wires or Electrodes	_____	_____
Hearing Aid	_____	_____
IUD	_____	_____
Stents/Shunts	_____	_____
Joint Replacements	_____	_____
Rods/Pins/Screws	_____	_____
Metal Plate/Metal Mesh	_____	_____
Shrapnel/Bullet Fragments	_____	_____
Any Prosthesis (eye, ear, penile, leg)	_____	_____
Tattoos	_____	_____
Body Piercing	_____	_____
Removable Dental Appliances	_____	_____
Metal Implants not mentioned	_____	_____
Wound Dressing (i.e. Acticoat 7)	_____	_____

Have you ever done/had ?	**YES**	**NO**
Welding	_____	_____
Grinding	_____	_____
Machine Work	_____	_____
Metal Lathe Work	_____	_____
Metal in your Eye	_____	_____
Asthma	_____	_____
Sickle Cell Anemia	_____	_____
Congestive Heart Failure	_____	_____
Diabetes	_____	_____
Kidney problems or disease	_____	_____
Head or Brain Surgery	_____	_____

Please circle the answer to the following:

Do you have leg pain or numbness?	YES	NO
Do you have arm pain or numbness?	YES	NO
Do you have lower back pain?	YES	NO
If yes to lower back pain, have you had:		
1) Physical therapy within last 60 days?	YES	NO
2) A chiropractor visit within last 60 days?	YES	NO
3) Physician care for greater than 28 days And less than 60 days?	YES	NO

Which side of your body are you experiencing pain?
LEFT RIGHT BOTH

How long have you had Pain?_____

Please describe any other symptoms or pain:_____
_____
_____

Trauma or Accident related to current problem? YES NO
_____
_____

Were you ever diagnosed with Cancer? YES NO
Type: _____

List ALL Previous Surgeries: _____
_____
_____
_____

DO NOT BRING THE FOLLOWING INTO THE SCAN ROOM:

Pagers	Glasses	Credit Cards	Keys
Watches	Safety Pins	Hair Pins	Coins
Belt Buckles	Pocket Knifes	Jewelry	Phones

Any Metal Objects or Electronic Devices
A LOCKER WILL BE PROVIDED FOR YOUR BELONGINGS.

MRI Tech Notes _____
_____

I realize the importance of this questionnaire and have answered all questions truthfully. Any and all questions I may have had concerning this examination have been answered and I am in agreement with having this MRI scan performed.

_____ _____
Patient or Patient Representative Signature *Date* *Staff Signature* *Date*

_____*(Relationship to Patient)*

(Rev 8/17)