

MRI PATIENT SCREENING FORM

Date: \_\_\_\_\_ Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Weight: \_\_\_\_\_

Yes	No	
_____	_____	Do you have (or previously had) a cardiac pacemaker?
_____	_____	Have you had surgery on your brain? If yes, what? _____
_____	_____	Do you currently have brain vessel clips from surgery?
_____	_____	Have you ever had ear surgery or any type of ear implants? If yes, what? _____
_____	_____	Have you had heart surgery? If yes, ( <b>please circle</b> ): Bypass Heart valves Aortic Clips Stent
_____	_____	Are you wearing? ( <b>please circle</b> ): hearing aids removable dentures/partials
_____	_____	Do you have any metal in your body? If yes, what? _____
_____	_____	Have you ever had a metal injury to your eyes that left metal fragments?
_____	_____	If you have had a metal piece/fragment in your eye(s) was it removed by a physician?
_____	_____	Have you ever had any type of cancer? Type: _____ Date of diagnosis: _____
_____	_____	Are you claustrophobic (afraid of small places)?
_____	_____	Are you <b>currently</b> wearing a medication skin patch?
_____	_____	<b>(Females)</b> Is there any possibility that you are pregnant?
_____	_____	Do you have permanent eyeliner or eyelid tattoo?
_____	_____	Are you wearing implanted/patch type TENS unit or pain control device?
_____	_____	Are you <b>currently</b> using an Insulin Pump?
_____	_____	Have you had surgery to the site being scanned today? When? _____
_____	_____	Do you <b>currently</b> have any form of kidney disease?
_____	_____	Have you had a previous study on the body part we are scanning today? If yes please list:
_____	_____	MRI: Facility: _____ When: _____
_____	_____	CT: Facility: _____ When: _____
_____	_____	X-Ray: Facility: _____ When: _____
_____	_____	Bone Scan: Facility: _____ When: _____

\*\*WHEN IS YOUR NEXT DOCTOR'S APPOINTMENT? \_\_\_\_\_