MRI Screening Form

Date:_____

Last name: _____ First name: _____

DOB: _____ Age: _____ Height: _____ Weight: _____

Male / Female **(please circle)**

Please describe your symptoms/injury or reason for the procedure?

_____

_____

How long have you had these symptoms? _____

MEDICAL HISTORY SCREENING PLEASE ANSWER THE FOLLOWING (YES OR NO)

Have you ever had small metal shavings embedded into your eyes? Yes No

Do you have a Cardiac Pacemaker? Yes No

Bullets or Shrapnel	Yes No	**Cochlear Implants/Hearing Aid**	Yes No
Heart Surgery	Yes No	**Removable Dentures/Partials**	Yes No
Vascular Filter or Stint	Yes No	**Cataracts or eye implants**	Yes No
Arotic Clips	Yes No	**Tattoo,permanent eye/lip liner**	Yes No
Brain Surgery	Yes No	**Piercings (other than ear)**	Yes No
Aneurysm Clips	Yes No	**IUD**	Yes No
Body Part _____		**Penile Implants**	Yes No
Carotid Clips	Yes No	**Medication/Heat Patch**	Yes No
Neurostimulator/Implanted Pump	Yes No	**Harrington Rods (spinal rod)**	Yes No
Tens Units(Nerve Stimulator)	Yes No	**History of Cancer**	Yes No
History of Stroke	Yes No	**Respiratory Disorders**	Yes No
Date of Stroke _____		**Artificial Limbs/Replacements**	Yes No
Sickle Cell Anaemia	Yes No	**Body Part** _____	
Diabetes	Yes No	**Any Chance of Pregnancy**	Yes No
Kidney Disease/Renal Failure	Yes No	**Breast Feeding Patients**	Yes No

Do you have any other metal / medical device inside your body? Yes No

If yes, please list: _____

Previous medical history: Have you had any prior surgeries? _____

_____

Are you allergic to any type of food,medications or imaging contrast (dye) Yes No

If yes, what type ? _____

I understand the information presented to me and have answered the questionnaire to the best of my knowledge. **If receiving IV contrast please refrain from eating 4 hrs prior to exam.**

_____	_____	_____
Signature of person providing information	**Relationship to patient**	**Date**

FOR IMAGING PERSONNEL ONLY
Technologist Comments:
_____
_____

Technologist Signature: _____