MRI Screening

Patient Name: _____ **MRN:** _____

□ Y □ N **Have you had a previous MRI?** If yes, Where/When? _____

□ Y □ N **Are you claustrophobic?**

□ Y □ N **Do you have a cardiac pacemaker, AICD, pacemaker wires?**

□ Y □ N **Have you ever had anything surgically implanted in your body?** (i.e. stent, aneurysm clip, neuro-stimulator, heart valve, medication pump, endoscopic clip, etc.) _____

□ Y □ N **Do you have external or accessory devices?** _____

□ Y □ N **Have you had any brain, eye or ear surgeries?** If yes, please describe _____

□Y □ N **Have you ever been diagnosed with cancer?** If yes,what type: _____
When was your last chemo/radiation treatment? _____

□ Y □ N **Have you had tattoos or permanent make-up applied?** _____

□ Y □ N **Have you ever done welding or grinding without protective eyewear?**

□ Y □ N **Have you ever had an accident or injury in which metal became lodged in your eye(s) or any other part of your body?** If yes, please describe: _____

□ Y □ N **Do you have a pessary ring or other intrauterine device?**

□ Y □ N **Are you pregnant, nursing or actively trying to get pregnant?**

□ Y □ N **Do you wear a hearing aid?**

□ Y □ N **Do you have dentures**(regular or magnetic), **partial plates, braces or retainers?** _____

□ Y □ N **Do you wear a medication patch?**

□ Y □ N **Have you ever had any other surgical procedures of any kind?**
If yes, please list: _____

□ Y □ N **Have you had any other medical imaging exams related to today's exam?**
If yes, where? _____

□ Y □ N **Do you have any special needs requiring assistance to stand or walk?**
walker,cane,wheelchair,caretaker,other disability _____

□ Y □ N **Pain Status: Can you lie still and flat for the duration of the study (30, 45 or 60 min) without moving?**
(If no,refer to Nursing/MRI for options)

□ Y □ N **Have you had an adverse reaction to MRI contrast medication?**

□ Y □ N **Have you taken aspirin or blood thinners in the last 30 days?** (for arthrograms only)

□ Y □ N **Are you taking any medications?** (sedate only) _____
_____

Your approximate weight: _____ **Approximate height:** _____

Patient signature: _____ **Date:** _____

OFFICE USE ONLY: Please do not write below this line.

Current medical symptom(s) & duration

1. _____
_____
_____

Lab Work Date Drawn: _____
Bun: _____
Creatinine: _____
GFR: _____

2. □ Y □ N Trauma? Cause: _____
3. □ Y □ N Food/Medication allergies? List: _____
4. Previously diagnosed diseases:

Kidney disease	□ Y □ N	Liver disease	□ Y □ N
Diabetes	□ Y □ N	Heart disease	□ Y □ N
Chronic disease	□ Y □ N	High blood pressure treatment	□ Y □ N
Respiratory problems	□ Y □ N	Rheumatoid arthritis or other	□ Y □ N

Follow up appointment: _____

Interviewer signature: _____ **Date:** _____

Rev. 02/3/2026