ARA POOLER IMAGING CENTER

MRI PATIENT HISTORY AND SCREENING FORM

Patient Name: _____ Sex: M F Weight: _____ Ht: _____

Date: _____ D.O.B: _____ Age: _____ Referring Physician: _____

Reason you are here today? Explain your medical problem in detail. (What is the problem? Where is the problem? Etc...)

_____

_____

Is your problem related to an injury? ☐ Yes ☐ No If yes, Date of injury? _____

How were you injured? ☐ Work ☐ Motor Vehicle Accident ☐ Other

Do you have or have you ever had any of the following?

☐ Yes ☐ No Cardiac Pacemaker: _____

☐ Yes ☐ No Heart Surgery/Heart Valve: If Yes, explain: _____

☐ Yes ☐ No Implanted Cardiac Defibrillator (ICD): _____

☐ Yes ☐ No Brain Aneurysm Clips/ Brain Surgery: If Yes, explain: _____

☐ Yes ☐ No Shunts/Stents/Filters/Intravascular Coil: _____

☐ Yes ☐ No Eye Surgery/Implants/Spring/Wires/Retinal Tack: _____

☐ Yes ☐ No Injury to the Eye Involving Metal or Metal Shavings: _____

☐ Yes ☐ No Orthopedic Pins/Screws/Rods/Joints/Prosthesis: _____

☐ Yes ☐ No Neurostimulator/Biostimulator: _____

☐ Yes ☐ No History of Cancer or Tumors: When: _____ Where: _____

☐ Yes ☐ No Radiation Therapy/Chemo Therapy: _____

☐ Yes ☐ No Previous Back Surgery (Lumbar/Thoracic/Cervical): When: _____ Levels: _____

☐ Yes ☐ No Ear Surgery/Cochlear Implants/Hearing Aids/Stapes Prosthesis: _____

☐ Yes ☐ No Vascular Access Port/Catheter: _____

☐ Yes ☐ No Metal Mesh Implants/Wire Sutures/Wire Staples or Clips/Internal Electrodes: _____

☐ Yes ☐ No Electrical/Mechanical/Magnetic Implants? Type: _____

☐ Yes ☐ No Implanted Drug Infusion Pump/Insulin Pump: _____

☐ Yes ☐ No Are you Pregnant? When was your last Menstrual Period/Cycle? _____

☐ Yes ☐ No Tattoo's/Permanent Make-up/Body Piercing/Patches: _____

☐ Yes ☐ No Dentures/Partials/Dental Implants: _____

☐ Yes ☐ No Gunshot Wounds/Shrapnel/BB: _____

☐ Yes ☐ No Do you have pins in your Hair/Clothes/Hair Extensions/Hair Pieces/Wig: _____

List Previous Surgeries: _____

MRI Contrast History: ☐Not applicable to this exam

Have you ever had MRI contrast? ☐ Yes ☐ No

Did you have any kind of reaction? ☐ Yes ☐ No If yes, explain: _____

Are you breast feeding at this time? ☐ Yes ☐ No

** Do you have any history of Renal disease? ☐ Yes ☐ No

** Do you have any history of Hypertension? ☐ Yes ☐ No

** Do you have any history of Diabetes? ☐ Yes ☐ No

**Have you ever had severe hepatic disease or liver transplant or pending liver transplant? ☐ Yes ☐ No

I attest that the above information is correct to the best of my knowledge. I have also informed the technologist that I am not pregnant at this time and I give consent to have a contrast agent administered to me if needed for proper diagnosis of my procedure. I acknowledge that I am aware of the possibility of side effects with contrast and I have had the opportunity to ask questions related to this form, to ask questions regarding the MRI procedure, and I understand the information presented to me.

X_____ _____ _____

Patient/Parent/Legal Guardian | MRI Technologist's Signature | Date

_____ _____ _____

Amount & Type of Contrast | Lot Number | Expiration Date

Valium: Mg:_____ Time:_____ By:_____