MRI PATIENT HISTORY / SAFETY SCREENING

NAME: _____ DATE OF BIRTH: _____

AREA TO SCAN: _____

DO YOU HAVE A FOLLOW UP APPT WITH YOUR PHYSICIAN CONCERNING TODAY'S EXAM? _____

IF YES, WHEN? _____

HEIGHT: _____ WEIGHT: _____

HAVE YOU HAD A PREVIOUS MRI OF THE AREA BEING SCANNED TODAY? _____

IF YES, WHEN AND WHERE: _____

ARE YOUR HAVING PIN, WEAKNESS, OR NUMBNESS IN EITHER OF YOUR ARMS OR LEGS? _____

IF YES, PLEASE SELECT ALL THAT APPLY:
LEFT ____ RIGHT ____
LEG ____ ARM ____

IS THIS AN INJURY RESULTING FROM AN ACCIDENT? _____ ACCIDENT DATE:_____

PLEASE SELECT IF YOU HAVE HAD SURGERY ON ANY OF THE FOLLOWING. IF YES, PLEASE INDICATE WHAT TYPE & WHEN:

SKULL Y ___ N ___ If so, what type:_____ When: _____

NECK/CERVICAL Y ___ N ___ If so, what type:_____ When: _____

LUMBAR/LOW BACK Y ___ N ___ If so, what type:_____ When: _____

ABDOMEN Y ___ N ___ If so, what type:_____ When: _____

OTHER Y ___ N ___ If so, what type:_____ When: _____

HAVE YOU EVER HAD CANCER? _____ IF SO, WHAT TYPE :_____

ARE YOU PREGNANT?_____

Because some metallic implants or items can interfere with or be hazardous to you during this study, select all that apply on this list to determine whether there are any contraindications to you having this study. Also, please inform the technologist of this before your exam.

___Pacemaker	___Hearing aids or implants	___Shunts, Spinal, Ventricular
___Aneurysm clips	___Shrapnel, bullets	___Intrauterine device
___Heart valves/stents	___Joint replacements	___Bone or joint pins, wire sutures
___Neurostimulator	___Prosthesis	___Metal in your eyes
___Insulin/Pain pump	___Metal plates, pins, screws	___Dentures, partials in mouth

If you select any of the above, please explain: _____

_____ Date: _____

I HAVE READ AND UNDERSTAND ALL THE QUESTIONS PERTAINING TO MRI SCANNING.

PATIENT/GUARDIAN SIGNATURE:_____
Technologist_____ RT(R)(MR)_____