FREDERICK RADIOLOGY

Diagnostic Center

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MRI SCREENING FORM

Some of the following items may be hazardous to your safety and some can interfere with the MRI examination.
Please check the correct answer for each of the following.

Name: ______________________ **Sex: M F** **Weight:** __________ **Height:** ___________
Date: _____________ **Date of Birth:** ________________ **Age:** ________

Do you have or have you ever had any of the following? (Circle Yes or No)

Yes No Cardiac Pacemaker: ____________________
Yes No Heart Surgery/ Heart Valve: If Yes, explain: ____________________
Yes No Implanted Cardiac Defibrillator (ICD/ Pacer Wires: ____________________
Yes No Brain Aneurysm Clip/ 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/ Implanted Radiation Seeds: When: ________ Where: ____________
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/ Penile Implant? Type: ____________________
Yes No Implanted Drug Infusion Pump/ Insulin Pump: ____________________
Yes No Are you Pregnant? When was your last Menstrual Cycle? ____________________
Yes No Tattoos'/ Permanent Make-up/ Body Piercing/ Patches: ____________________
Yes No Dentures/ Partials/ Dental Implants: ____________________
Yes No Gunshot Wounds/ Shrapnel: ____________________
Yes No Do you have pins in your hair/ cloths/ hair extensions/ hair pieces/ wig? ____________________
Yes No IUD (women only): ____________________
Yes No Images requested by referring Dr.? (If yes, CD or Film?) ________________

MRI CONTRAST HISTORY: **Skip If Not Applicable to this Exam**

Have you ever had MRI Contrast injection? 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 (Kidney) 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(liver) disease, liver transplant or pending liver transplant? Yes No

______________________________ ______________ ______________
Amount and Type of Contrast Lot Number Expiration Date

I attest that the above information is correct to the best of my knowledge. I have read and understand the contents of this form and I have had the opportunity to ask questions regarding the information on this form.

X ______________________________ ______________________________ ____________
Patient/ Parent/ Legal Guardian MRI Technologist's Signature Date

COMMENT: ____

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