MRI Screening Form

Name_____ DOB_____ Age_____ Wt_____
Today's Date_____ Referring Doctor_____
Your Symptoms/Reason for this Exam

_____

_____

Surgical History_____
History of Cancer?_____
Have you had MRI before?
Type_____ Date_____ Location_____

The following may be dangerous or interfere with your MRI.
Females: Chance of pregnancy? YES NO LMP_____ Breastfeeding? Y N

Surgery or procedure in the last 6 weeks?	YES	NO
Do you work with metals (grinding, polishing, cutting)?	YES	NO
Cardiac pacemaker, defibrillator	YES	NO
Artificial heart valves	YES	NO
Cochlear implants	YES	NO
Aneurysm clips	YES	NO
Intravascular coil, filter, port, catheter	YES	NO
Implants—infusion device, pump, eye, ear, joint, mesh, penile	YES	NO
Metal in body—Shrapnel, bullets	YES	NO
Other device in body—IUD, pin, screw, clip, rod	YES	NO

Other_____

Patient Signature_____ Date_____

Tech Comments_____

_____

Reviewed by Tech (Signature)_____ Date _____