MRI Q 1

A DBA of Five Towns Neurology, PC
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MRI HISTORY AND SCREENING FORM

Patient name: ________________________________ Date of Birth: ____/____/____

Sex: M F Height: _______ Weight: __________

What MRI are you here for today? ___________________

HAVE YOU HAD A RECENT MRI? ❑ Yes ❑ No If yes, Open MRI or Closed? Date done: ____/____/____

Is this problem related to any injury? ❑ Yes ❑ No If yes, what date was injury? ____/____/____

How did injury occur? ❑ Work ❑ Motor Vehicle Accident ❑ Slip and Fall ❑ Other

Have you had (or plan to have) any sedation/alcohol today (as to relax you for this procedure)? ❑ Yes ❑ No

If yes, what exactly and how much? _________

If yes, do you have someone who can drive you home? ❑ Yes ❑ No

Do you currently have or have you EVER HAD any of the following?

1 ❑ Yes ❑ No Cardiac Pacemaker: ____________________________

2 ❑ Yes ❑ No Heart Surgery/Heart Valve: If Yes, please explain (exact valve type if known): __________

3 ❑ Yes ❑ No Implanted Cardiac Debrillator (ICD): ________________________

4 ❑ Yes ❑ No Brain Aneurysm Clips/Brain Surgery: If Yes, explain: ______________________________

5 ❑ Yes ❑ No Shunts/Stents/Filters/Intravascular Coils: _______________________________________

6 ❑ Yes ❑ No Eye surgery/Implants/Spring/Wires/Retinal Tack: _________________________________

7 ❑ Yes ❑ No Injury to the Eye Involving Metal or Metal Shavings: ________________________________

8 ❑ Yes ❑ No Orthopedic Pins/Screws/Rods/Joints/Prosthesis: _________________________________

9 ❑ Yes ❑ No Neurostimulator/Biostimulator: ____

10 ❑ Yes ❑ No History of Cancer or Tumor: When: ______________ Where: _______________________

11 ❑ Yes ❑ No Radiation Therapy/Chemotherapy: ____

12 ❑ Yes ❑ No Previous Back Surgery (Cervical/Thoracic/Lumbar): When: ________ Where: __________

13 ❑ Yes ❑ No Ear Surgery/Cochlear Implants/Hearing Aids/Staples/Prosthesis: _____________________

14 ❑ Yes ❑ No Vascular Access Port/Catheter: ____

15 ❑ Yes ❑ No Metal Mesh Implants/Wire Sutures/Wire Staples or Clips/Internal Electrodes: ___________

16 ❑ Yes ❑ No Electrical/Mechanical/Magnetic Implants? Type: _________________________________

17 ❑ Yes ❑ No Implanted Drug Infusion Pump/Insulin Pump: ____________________________________

18 ❑ Yes ❑ No Are you possibly pregnant? When was your last Menstrual Period/Cycle? _____________

19 ❑ Yes ❑ No Any Tattoo's/Permament Make-up/Body Piercing/Patches: _________________________

20 ❑ Yes ❑ No Dentures/Partials/Dental Implants: ____

21 ❑ Yes ❑ No Gunshot Wounds/Shrapnel/BBs: ____

22 ❑ Yes ❑ No Do you have pins in your Hair/Clothes/Hair Extensions/Hair Pieces/Wig: ______________

Drug Allergies: ___________________________ Previous Surgeries: ___________________________

Current Medication: ____

MRI Q 2

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MRI HISTORY AND SCREENING FORM - cont. page 2

MRI Contrast History ❑ Not applicable to this exam

a. Have you ever had MRI contrast? ❑ Yes ❑ No

b. If so, did you have any kind of reaction? ❑ Yes ❑ No

c. Have you ever had a previous MRI of the same body part? ❑ Yes ❑ No

d. Is there any chance you could be pregnant now? ❑ Yes ❑ No

e. Are you nursing at this time? ❑ Yes ❑ No

f. Do you have any history of liver/renal disease? ❑Yes ❑ No

g. Do you have any history of Hypertension? ❑ Yes ❑ No

h. Do you have any history of Diabetes? ❑ Yes ❑ No

i. Do you have Multiple Sclerosis? ❑ Yes ❑ No

j. 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 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 for this procedure. I am aware of the possibillity of side effects with contrast and I have the opportunity to ask questions related to this form, to ask questions regarding the MRI procedure and I understand the information presented to me.

Patient/Parent/Legal Guardian Name: ____________________ Signature: ____________________

MRI Technologist Name: ____________________ Signature: ____________________

Date: ____/____/____

FOR TECHNOLOGIST USE ONLY:

Type of Contrast: ____________________ Lot Number: ________________ Exp Date: ____________________

Time of Injection: ____________________ Amount given: ____________________