MRI PATIENT HISTORY/ SAFETY SCREENING

NAME:_____ **DATE OF BIRTH:**_____

AREA TO SCAN:_____

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

IF YES, WHEN?_____

WEIGHT:_____ **HEIGHT:**_____

HAVE YOU HAD A PREVIOUS MRI OF THE AREA BEING SCANNED TODAY?_____ **IF YES, WHEN AND WHERE:**

_____

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

IF YES, PLEASE CIRCLE ALL THAT APPLY: RIGHT OR LEFT

LEG OR ARM

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

PLEASE CIRCLE IF YOU HAVE HAD SURGERY ON ANY OF THE FOLLOWING. IF YES, PLEASE INDICATE WHAT TYPE AND WHEN.

SKULL	**Y**	**N**	**If so, what type:**_____
NECK/CERVICAL	**Y**	**N**	**If so, what type:**_____
LUMBAR/LOWER BACK	**Y**	**N**	**If so, what type:**_____
ABDOMEN	**Y**	**N**	**If so, what type:**_____
OTHER	**Y**	**N**	**If so, what type:**_____

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, please indicate that by circling 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 valve/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 circled any of the above, please explain:_____

_____

_____ **DATE:**_____
I HAVE READ AND UNDERSTAND ALL THE QUESTIONS PERTAINING TO MRI SCANNING.
SIGNATURE OF PATIENT OR GUARDIAN (IF MINOR)

Technologist: **RT(R)(MR)**_____