MAGNETIC RESONANCE (MR) PROCEDURE SCREENING FORM FOR PATIENTS

Date ____/____/____ Patient Number _____

Name _____ Age _____ Height _____ Weight _____
Last name First name Middle Initial

Date of Birth ____/____/____ Male ❒ Female ❒ Body Part to be Examined _____
month day year

Address _____ Telephone (home) (____) ____-____

City _____ Telephone (work) (____) ____-____

State _____ Zip Code _____

Reason for MRI and/or Symptoms _____

Referring Physician _____ Telephone (____) ____-____

1. Have you had prior surgery or an operation (e.g., arthroscopy, endoscopy, etc.) of any kind? ❒ No ❒ Yes
   If yes, please indicate the date and type of surgery:
   Date ____/____/____ Type of surgery _____
   Date ____/____/____ Type of surgery _____
2. Have you had a prior diagnostic imaging study or examination (MRI, CT, Ultrasound, X-ray, etc.)? ❒No ❒ Yes

If yes, please list:	Body part	Date	Facility
MRI	_____	____/____/____	_____
CT/CAT Scan	_____	____/____/____	_____
X-Ray	_____	____/____/____	_____
Ultrasound	_____	____/____/____	_____
Nuclear Medicine	_____	____/____/____	_____
Other_____	_____	____/____/____	_____

3. Have you experienced any problem related to a previous MRI examination or MR procedure? ❒ No ❒ Yes
   If yes, please describe: _____
4. Have you had an injury to the eye involving a metallic object or fragment (e.g., metallic slivers, shavings, foreign body, etc.)? ❒ No ❒ Yes
   If yes, please describe: _____
5. Have you ever been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel, etc.)? ❒ No ❒ Yes
   If yes, please describe: _____
6. Are you currently taking or have you recently taken any medication or drug? ❒ No ❒ Yes
   If yes, please list: _____
7. Are you allergic to any medication? ❒ No ❒ Yes
   If yes, please list: _____
8. Do you have a history of asthma, allergic reaction, respiratory disease, or reaction to a contrast medium or dye used for an MRI, CT, or X-ray examination? ❒ No ❒ Yes
9. Do you have anemia or any disease(s) that affects your blood, a history of renal (kidney) disease, renal (kidney) failure, renal (kidney) transplant, high blood pressure (hypertension), liver (hepatic) disease, a history of diabetes, or seizures? ❒ No ❒ Yes
   If yes, please describe: _____

For female patients:

10. Date of last menstrual period: ____/____/____ Post menopausal? ❒ No ❒ Yes
11. Are you pregnant or experiencing a late menstrual period? ❒ No ❒ Yes
12. Are you taking oral contraceptives or receiving hormonal treatment? ❒ No ❒ Yes
13. Are you taking any type of fertility medication or having fertility treatments? ❒ No ❒ Yes
    If yes, please describe: _____
14. Are you currently breastfeeding? ❒ No ❒ Yes