



**NORTHERN
ARIZONA
RADIOLOGY**

MRI Patient History and Screening form

Patient Name _____

Patient Date of Birth _____

Sex: M F Weight _____ Ht _____

Do you have or have you ever had the following?

YES NO

- ____ Pacemaker
- ____ Implanted cardiac defibrillator
- ____ Cochlear implant
- ____ Brain aneurysm clip
- ____ Brain surgery _____
- ____ Have you ever been a machinist, welder, or metal worker?
- ____ Have you ever been hit in the face or eye with a piece of metal?
- ____ Have you ever had a piece of metal removed from your eye?
- ____ IUD / Diaphragm / Pessary
- ____ Small bowel endoscopy capsule
- ____ Heart surgery / Heart valves, Stents _____
- ____ Shunts / Intravascular coil _____
- ____ Ear surgery _____
- ____ Eye surgery / Implants _____
- ____ Neurostimulator / Biostimulator / Bone growth stimulator _____
- ____ Vascular access port _____
- ____ Metal mesh implant / Wire sutures / Wire staples / Internal electrode
- ____ Any electrical, mechanical, or magnetic implants. Type: _____
- ____ Implanted drug infusion pump / Insulin pump _____
- ____ Orthopedic pins, screws, rods etc. _____
- ____ Dentures, partials or dental implants, braces _____
- ____ Gunshot wounds, shrapnel, bb's _____
- ____ Hearing aid
- ____ Do you have tattoos or permanent makeup _____
- ____ Skin patches (nitroglycerine, stop-smoking patches)

As part of your exam, the radiologist may deem it advisable to give you an IV injection of a contrast agent containing gadolinium. Although gadolinium contrast has been used safely in millions of cases, minor reactions (headache or nausea) occur in about 2% of patients. Serious or life-threatening reactions have been reported in about one in 400,000 patients.

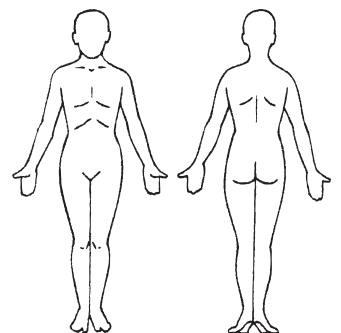
YES ____ NO ____ have you ever had an allergic reaction to gadolinium contrast material?

Using the body chart, place and "X" on the area of your pain and / or symptoms.

Please circle the number that represents your pain level.

0 is no pain and 10 is severe pain.

0 1 2 3 4 5 6 7 8 9 10



What is the cause of your injury? _____

Please list recent tests relating to this injury. (MRI, CT, X-ray)

TEST	WHEN	WHERE	RESULTS

Please list surgeries you have had. Please give procedures and dates if possible.

List any allergies you have _____

Have you ever had the following

High blood pressure	___ YES ___ NO	Seizures	___ YES ___ NO
Heart / Circulation disorders	___ YES ___ NO	Dizzy Spells	___ YES ___ NO
Arthritis / Osteoarthritis	___ YES ___ NO	Diabetes	___ YES ___ NO
Immune deficiency disease	___ YES ___ NO	Cancer	___ YES ___ NO

Have you had any recent trouble with vision? _____

Have you had any trouble with hearing? _____

Have you had unusual weight gain or loss lately? _____

FOR WOMEN, are you pregnant? _____

I have answered these questions to the best of my knowledge and understanding information presented to me.

Patient / Parent / Legal Guardian

Technologist Signature

Date