Magnetic Resonance Imaging Patient Screening Form

![WARNING: IF YOU HAVE A PACEMAKER, DEFIBRILLATOR OR ANEURYSM CLIP, DO NOT PROCEED WITH YOUR SCAN. PLEASE NOTIFY A STAFF MEMBER IMMEDIATELY.]

Patient Name: ___________________________ Today’s Date: ________________

Age: ____ Date of Birth: ________________ Weight: ________ Gender: ☐ Male ☐ Female

1. Have you ever had a prior surgical procedure of any kind? ☐ Yes ☐ No
   If yes, please indicate the date (approximate if unknown) and type of surgery:
   __________________________________________________________________________

2. Have you ever experienced any problem related to a previous MRI procedure? ☐ Yes ☐ No
   If yes, please explain: __________________________________________________________________________

3. Do you have any respiratory concerns that could prevent you from having a MRI procedure? ☐ Yes ☐ No
   If yes, please explain: __________________________________________________________________________

4. Have you ever been a welder, grinder, or sheet metal worker? ☐ Yes ☐ No
   If yes, please explain: __________________________________________________________________________

5. Have you had an eye injury involving a metallic object or fragment (metallic slivers, shavings)? ☐ Yes ☐ No
   If yes, please explain: __________________________________________________________________________

6. Have you ever been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel)? ☐ Yes ☐ No
   If yes, please explain: __________________________________________________________________________

7. Have you recently had a small bowel endoscopy/colonoscopy in the past 30 days? ☐ Yes ☐ No
   If yes, how recent: ____________________________________________________________________________

8. 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, or seizures? ☐ Yes ☐ No
   If yes, please explain: __________________________________________________________________________

9. Do you have a history of asthma, allergic reaction, respiratory disease, or reaction to contrast medium or dye used for MRI, CT, or x-ray procedures? ☐ Yes ☐ No
   If yes, please explain: __________________________________________________________________________

10. Have you ever had a reaction to or have been told that you should not have contrast medium injections for imaging studies? ☐ Yes ☐ No
    If yes, please explain: __________________________________________________________________________

For Female Patients:

11. Are you or could you be pregnant or experiencing a late menstrual period? ☐ Yes ☐ No

12. Do you have a diaphragm/IUD in place? ☐ Yes ☐ No

13. Are you currently breastfeeding? ☐ Yes ☐ No
I have reviewed the above information and attest that the information is accurate to the best of my knowledge. I have read and understand the entire contents of this form and had the opportunity to ask questions regarding this information and the MRI procedure.

Patient Name (please print):____________________________________________________________

Patient Signature:_____________________________________________ Date:____________

OFFICE USE ONLY:
Gadolinium: ______cc’s  Injection time: _______  Injection site: _______  Technologist: ______________

Physician signature: ___________________________ Date: _______  Time: _______

Technologist Notes: ______________________________________________________________________________________
______________________________________________________________________________________________________