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MRI PRE-SCREENING FORM

Patient Name: _____

Date of Birth: _____ Sex: ❑ M ❑ F Claustrophobic? ❑ Yes ❑ No

MRI EXAM: _____ Had you had an MRI before? ❑ Yes ❑ No

If yes, were there any issues? ❑ Yes ❑ No – Explain: _____

Have you had any surgeries of the Heart, Brain, Spine or Abdomen? ❑ Yes ❑ No

If yes, what was done and when? _____

When was the injury or how long have you been hurting? _____

How did the injury happen? (If applies) _____

Where is the pain right now? _____

Do you experience any of the following associated with the injury or pain:

❑ Swelling ❑ Burning ❑ Stabbing ❑ Aching ❑ Pressure ❑ Radiating Pain

Please indicate if you have any of the following:	YES	NO
Cardiac Pacemaker/Cardiac Valve Replacement/Cardiac Stent(s)?	❑	❑
Brain Aneurysm Clip/Shunt?	❑	❑
Aortic Clip(s)/Surgical Clip(s)?	❑	❑
Implanted Neurotransmitter/Electronic Device?	❑	❑
Insulin Pump/Infusion Device (Internal or External)?	❑	❑
Removable Hearing Aid(s)? (Must Be Removed)	❑	❑
Cochlear Implant/Other Internal Hearing Aid(s)?	❑	❑
Prosthetic Device(s)?	❑	❑
Joint Replacement(s)/Metal Rod(s)/Plate(s)/Screw(s)/Nail(s)?	❑	❑
If yes, Has It Been Post Op Six Weeks?	❑	❑
Shrapnel/Bullet/Any Other Foreign Body?	❑	❑
Have You Had an Eye Injury Involving Metal?	❑	❑
Body Piercing(s)? (Must Be Removed)	❑	❑
Known Allergies? If yes, List:	❑	❑
Fainting/Dizzy Spells?	❑	❑
Do You Have Any Metal Removal Partials?	❑	❑
All Jewelry Removed? (i.e. watches/rings/necklaces/hair pins/bracelets, etc.)	❑	❑

_____

Signature of Patient or Guardian Date

_____

Signature of Person Conducting Screening Date