



MRI History & Screening

Date of scan _____

Name _____ MRN _____

DOB _____ Age _____ Weight _____ Ordering Doctor _____

Symptoms _____

The following items can interfere with images and some may be hazardous to your safety. Please indicate if you have any of the following:

	Yes	No		Yes	No
Neurostimulators (Tens Units)			Medication patch		
Internal electrodes or wires			Radiation seeds		
Heart valve replacement			Breast implant / tissue expander		
Brain surgery of any kind			Greenfield, or vena cava filter		
Aneurysm surgery			Hearing aids		
Ear or eye surgery			Implanted medication pumps		
Spinal or ventricular shunt			IUD or diaphragm		
Vascular port access			Penile prosthesis		
Seizures or epilepsy			Cancer, chemotherapy, or radiation therapy		
Joint replacement			Pregnant or breast feeding		
Metal plates, pins, screws, wires			Renal or liver disease		
Wounded by bullets or shrapnel			Blood disorder, i.e. anemia or diabetes		
Body piercing			Respiratory problems		
Tattoos or permanent eye liner			Hypertension		
Pessary			Claustrophobia—fear of small spaces		

Please list any surgeries you have had: _____

Have you in your lifetime worked around metal or performed metal grinding or welding, including auto body work? _____

Have you ever gotten metal in your eyes? _____

Do you have any drug allergies or reactions? _____

Have you ever had an MRI scan before? _____

Please remove any of the following items prior to your exam:

glasses, hearing aids, removable dental work, watch/jewelry, wallet, credit cards, keys, wigs/hairpiece, hairpins/clips, safety pins, and bra.

I hereby certify the above information is correct to the best of my knowledge:

Patient: _____ **Date:** _____

Technologist: _____ **Date:** _____