MRI Pre-Entry Screening

Please fill out this form to the best of your ability. If you do not know exact dates, just estimate. This information is very important and will be reviewed during the interpretation of your MRI.

Last Name:___________________________First Name:_____________________________

Age:_______Date of Birth:_______________

Dominant Hand:_____________Height:_______Weight:________Gender: M / F

Work Related?________Auto Related?________Date of Accident: __________________

These questions apply only to the area being scanned today

What are you being seen for? ____

Describe your symptoms and the duration. ______________________________________

____

Is this due to repetitive stress? ___Yes___No

What makes it better?____

____

What makes it worse?____

____

Do you have areas of weakness? ___Yes___No

If yes, where?____

Do you have arthritis in any of your joints? ___Yes ___ No

If yes, list joints:____

Are you currently taking any medications? ___Yes ___No

If yes, list medications: ____

____

Do you have any other medical conditions? ____Yes ____ No

If yes, list conditions:____

____

____

List athletic activities that may have contributed to your condition:___________________

____

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Pacemaker, pacer wires and/or implanted cardiac defibrillator? ________________YES/NO
If YES, notify us immediately.
Brain aneurysm clips? **If YES, notify us immediately.**_________________________YES/NO
Have you ever had an MRI scan before? Body part:________________Date:_______YES/NO
Have you ever had surgery on the area to be scanned?_________________________YES/NO
Procedure:_____________________________Date:_____________
Have you *EVER* had a metal injury to your eyes? _______________________________YES/NO
If yes, please notify us immediately.
Have you had an MRI since the incident of metal to your eyes?__________________YES/NO
Are you clinically claustrophobic?____YES/NO
Do you have a history of cancer?____YES/NO
Do you have any major medical problems? Please list._________________________YES/NO
Are you pregnant or could you be pregnant? ___________________________________YES/NO
If yes, please notify us immediately.

Please Circle The Appropriate Response:

Neuro-stimulator?_________________Y/N
Bone growth stimulator?___________Y/N
Joint replacements?_______________Y/N
Other metal (rods, shrapnel,
Screws, bullets)?_________________Y/N
Wires/sutures/clips?______________Y/N
Eye prosthesis?__________________Y/N
Inner ear implants (cochlear,
Stapes)?_________________________Y/N
Insulin pump?____________________Y/N
Morphine pump?__________________Y/N
Magnetic dental implant?__________Y/N

Heart valve?___________________Y/N
Greenfield filter?_______________Y/N
Vascular stent?________________Y/N
Penile implant?________________Y/N
Tattoos?______________________Y/N
Tattooed eyeliner?_____________Y/N
Hearing Aids?_________________Y/N
Harrington rods?_______________Y/N
Electronic device?_____________Y/N
Infusion pump?________________Y/N
Chemo pump?_________________Y/N
Removable denture work?______Y/N

Notes from the Technologist

Please Read Prior to Signing

You must remove all metallic objects including: easily removable jewelry, bras, shoes, belts, hair pins, safety pins, paperclips, money clips, coins, pens, watch, etc. If you have any body piercings (other than ears) please let the Technologist know. Your signature on this form indicates that you authorize and consent to the performance of this procedure.

Patient Signature or Representative (if minor) Date

MRI Technologist Date

Updated 01/2021