

Name _____ Date _____ Date of Birth _____ Age _____ Sex _____ Height _____ Weight _____

Today's MR procedure: _____ Reason for this exam (Explain current Problem _____

- 1. Do you have a cardiac pacemaker? Yes No
 - External cardiac monitoring system or device? Yes No
 - Implanted cardiac defibrillator? Yes No
 - Internal pacing wires? Yes No
- 2. Have you had any other exam (i.e., CT, US, X-Ray, Nuclear Medicine) which pertains to your current problem Yes No

When? _____ Where? _____ What did it show? _____

- 3. Have you ever had a MRI or CT before? (Where: _____ When: _____) Yes No
- 4. Are you claustrophobic? Yes No
- 5. Do you have any allergies to contrast? Yes No
- 6. Do you have any intravascular stents, filters, or coils?..... Yes No
- 7. Do you have Renal Failure, Renal Disease, Renal tumor, Solitary Kidney or Renal Transplant? Yes No
 - Are you on Renal Dialysis? Yes No
 - If yes, coordinate dialysis to immediately follow MRI/MRA procedure with contrast Yes No
 - Time/date dialysis is scheduled: _____
- 8. Do you have Hepatic (Liver) Disease, Liver Transplant, or Pending Liver Transplant?..... Yes No
- 9. Do you have High Blood Pressure/Hypertension? Yes No
- 10. Do you have Diabetes? Yes No

***Any answer of yes to 7-10 above requires lab GFR values if the patient needs contrast!**

- 11. Do you have any brain or abdominal aneurysm clips?(year, make & model _____) Yes No
- 12. Do you have any implants or orthopedic items? Yes No
- 13. Do you have any hearing aids (COCHLEAR IMPLANT)?..... Yes No
- 14. Do you have any metal in your body other than dental work? _____ Yes No
- 15. Have you had any shrapnel, BB's or gun shot wound? Yes No
- 16. Have you **ever** had metal removed from your eyes?(x-rays required)..... Yes No
- 17. Have you ever had surgery? Yes No
 - If yes, what type & when: _____
- 18. Do you have any **permanent** makeup, or tattoos ?..... Yes No
- 19. Are you able to lie still on your back comfortably? Yes No
- 20. Have you had any type of cancer? What type? _____ Yes No
- 21. Do you have seizures?..... Yes No
- 22. Side of Complaint: Right Left
- 23. Did you have an injury? Yes No
- 24. Are you wearing a trans-dermal medication patch..... Yes No

List all allergies (including drug allergies) _____

Female Patients:

- 1. Are you pregnant, or could you possibly be pregnant? Yes No
- 2. Are you breastfeeding? Yes No
- 3. Are you taking oral contraceptives or hormonal replacement? Yes No
- 4. Date of your last menstrual period _____
- 5. Post Menopausal Yes No

Upon arriving in the department:

I acknowledge I have received ear protection. (Select One) YES NO

Patient Signature: _____ Date: _____ Screener: _____

MRI Information: Patient was scanned with hand held metal detector

Date of Procedure: _____ Time of Procedure: _____ Tech Signature: _____