

## MRI PATIENT SCREENING FORM

HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_

YES   NO

- \_\_\_   \_\_\_   \*Do you have (or previously had) a cardiac pacemaker?  
IF "YES", STOP NOW AND SEE RECEPTIONIST.
- \_\_\_   \_\_\_   \*Have you had surgery on your brain? If yes, what? \_\_\_\_\_  
\_\_\_   \_\_\_   \*Do you currently have brain vessel clips (from surgery?)
- \_\_\_   \_\_\_   \*Do you have artificial heart valves? \_\_\_ aortic clips? \_\_\_ Stent? \_\_\_\_\_
- \_\_\_   \_\_\_   \*Are you wearing hearing aids or REMOVABLE dentures/partials?
- \_\_\_   \_\_\_   \*Do you have metal in your body? (Other than dental work).
- \_\_\_   \_\_\_   \*Have you ever had any type of cancer? Type \_\_\_\_\_  
\_\_\_   \_\_\_   \*Any personal history of kidney disease?
- \_\_\_   \_\_\_   \*Are you **DIABETIC**?
- \_\_\_   \_\_\_   \*Date of last laboratory work \_\_\_\_\_ Where? \_\_\_\_\_  
\_\_\_   \_\_\_   \*Are you wearing a medication skin patch today? \_\_\_\_\_
- \_\_\_   \_\_\_   \*Are you claustrophobic?(Afraid of closed in places?)  
\_\_\_   \_\_\_   \*Are you wearing implanted/patch type TENS unit or pain control  
device?  
\_\_\_   \_\_\_   \*Are you currently using an insulin pump or electrodes?
- \_\_\_   \_\_\_   \*Have you had surgery to this site we are scanning today? When? \_\_\_\_\_
- \_\_\_   \_\_\_   \*IS YOUR NEXT DOCTOR'S APPT Today or Tomorrow?

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### HOW DID YOU HEAR ABOUT OUR FACILITY?

\_\_\_ MD   \_\_\_ FAMILY/FRIEND   \_\_\_ RADIO AD   \_\_\_ MAGAZINE AD   \_\_\_ OTHER

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Previous reports on today's study would be helpful to us.

MRI	Facility _____	When _____
Cat Scan	Facility _____	When _____
X-ray	Facility _____	When _____
Nuclear Bone Scan	Facility _____	When _____

**PLEASE PRINT YOUR NAME:** \_\_\_\_\_