MRI
PATIENT HISTORY / SCREENING

ADDITIONAL EXAMS ________________

Patient Name: ____ **DOB:** ________________

Date: ________________

OFFICE USE ONLY	BUN: __________	CREATININE: __________	DATE DRAWN: __________

Is there any possibility that you may be pregnant? ❑ Yes ❑ No Last menstrual period? ____________________

Are you currently breast feeding? ❑ Yes ❑ No

PLEASE INDICATE IF YOU HAVE ANY OF THE FOLLOWING:

Do you have a pace-maker or internal pacing wires? ❑ Yes ❑ No

Do you have aneurysm clips? ❑ Yes ❑ No If so, where____

Do you have an internal cardiac defibrillator? ❑ Yes ❑ No

Do you have a neuro-stimulator (tens unit) implanted in your body? ❑ Yes ❑ No

Have you had any surgery in the past six weeks? ❑ Yes ❑ No

Have you had any other surgery? ❑ Yes ❑ No

Type of surgery: ____ Date: ____________________

Have you ever been struck in the eye with any metal? ❑ Yes ❑ No

Have you ever been shot with a gun or pellet? ❑ Yes ❑ No

Have you had a stent, filter, or intravascular coil placement in the past 8 wks? ❑ Yes ❑ No

Do you have an insulin pump or pain pump implanted in your body? ❑ Yes ❑ No

Do you have a hearing aid or cochlear implant? ❑ Yes ❑ No

Do you have any type of prosthesis? ❑ Yes ❑ No

Have you ever been diagnosed with cancer? ❑ Yes ❑ No

Type of cancer: ____ When were you diagnosed? _______________

Type of treatment taken: ____

Are you currently undergoing radiation treatment? ❑ Yes ❑ No

Do you have metal anywhere inside your body? ❑ Yes ❑ No

Do you have surgically implanted breast tissue expander? ❑ Yes ❑ No

Do you have any dentures and/or partials? ❑ Yes ❑ No

Do have a history of ❑ hypertension (high blood pressure) ❑ diabetes
❑ congestive heart failure ❑ liver disease

Do you have a kidney disease, on dialysis, have only one kidney, or any other kidney problems? ❑ Yes ❑ No

PATIENT SIGNATURE:____