MRI Screening

**Patient Name:**

**MRN:**

|  |  |  |
| --- | --- | --- |
| □ Y  □ Y  □ Y  □ Y  □ Y | □ N  □ N  □ N  □ N  □ N | **Have you had a previous MRI?** If yes, Where/When?  **Are you claustrophobic?**  **Do you have a cardiac pacemaker?**  **Have you ever had anything surgically implanted in your body?** (i.e. stent, aneurysm clip, neuro*-* stimulator, heart valve, medication pump, etc.) **Have you had any brain, eye or ear surgeries?** If yes, please describe |
| □Y | □ N | **Have you ever been diagnosed with cancer?** If yes,what type: |
|  |  | When was your last chemo/radiation treatment? |
| □ Y  □ Y | □ N  □ N | **Have you ever done welding or grinding without protective eyewear?**  **Have you ever had an accident or injury in which metal became lodged in your eye(s) or any other part of your body?** If yes, please describe: |
| □ Y | □ N | **Do you have a pessary ring or other intrauterine device?** |
| □ Y | □ N | **Are you pregnant, nursing or actively trying to get pregnant?** |
| □ Y | □ N | **Do you wear a hearing aid?** |
| □ Y | □ N | **Do you wear a medication patch?** |
| □ Y | □ N | **Have you ever had any other surgical procedures of any kind?** |
|  |  | If yes, please list: |
| □ Y | □ N | **Have you had any other medical imaging exams related to today’s exam?** |
|  |  | If yes, where? |
| □ Y | □ N | **Do you have any special needs requiring assistance to stand or walk?** |
|  |  | walker,cane,wheelchair,caretaker,other disability |
| □ Y | □ N | **Pain Status: Can you lie still and flat for the duration of the study (30, 45 or 60 min) without moving?** |
|  |  | (If no,refer to Nursing/MRI for options) |
| □ Y | □ N | **Have you taken aspirin or blood thinners in the last 30 days?** (for arthrograms only) |
| □ Y | □ N | **Are you taking any medications?** (sedate only) |

**Your approximate weight:**

**Approximate height:**

**Patient signature: OFFICE USE ONLY: Please do not write below this line.**

**Date:**

**Current medical symptom(s) & duration Lab Work** Date Drawn**:**

1.

2.

3.

4.

5.

6. □ Y □ N Trauma? Cause:

7. □ Y □ N Food/Medication allergies? List:

Bun: Creatinine: GFR:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| 8. | Previously diagnosed diseases: | Kidney disease | □ Y | □ N | Liver disease | □ Y | □ N |
|  |  | Diabetes | □ Y | □ N | Heart disease | □ Y | □ N |
|  |  | Chronic disease | □ Y | □ N | High blood pressure treatment | □ Y | □ N |
|  |  | Respiratory problems | □ Y | □ N | Rheumatoid arthritis or other | □ Y | □ N |

**Follow up appointment:**

**Interviewer signature:**

**Rev. 06/14/2016**

**Date:**