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Magnetic Resonance Imaging/Patient History and Screening Information

ID # BRI _____
Patient Name (last/first/middle) _____
Mailing Address _____ Zip _____
Date of Birth _____ Social Security No. _____
Home Phone _____ Cell Phone _____ Work Phone _____
Sex (Male/Female) _____ Weight _____ Height _____
Medical Allergies _____
Reason for MRI Exam/Symptoms _____
When is your next doctor's appointment? _____ Doctor's Name _____

*** Please answer the questions pertinent to your condition:**

What was your chief complaint when you saw your doctor?

Describe your pain, if any (burning, sharp, etc.) _____
Does the pain involve any other part of your body? Yes No Where? _____
Do you have numbness? Yes No Weakness? Yes No Where? _____
Have you had surgery in the area being scanned today? Yes No If yes, what was done? _____
Where was the location of the facility where the surgery was performed? _____
Have you had any previous heart, brain or ear surgery? Yes No If yes, what was done? _____
Please list any other health problems or history of cancer you may have: _____

Have you had any X-rays, CT scans, Bone scans, PET scans or any previous MRI scans of the area being scanned today?
 Yes No If yes, where and when? _____

*** Please mark yes if you have any of the following:**

Yes No
- Pacemaker - Defibrillator - Electronic implant - Metal implants of any kind - Stent less than 6 months

*** Please mark yes if you have any of the following:**

Yes No (Underline specific item)
Aneurysm clips, magnetically-activated implant or device, neurostimulation system, spinal cord stimulator, internal electrodes or wires, bone growth/fusion stimulator; cochlear, otologic or other ear implant, insulin or other infusion pump, implanted drug infusion device; any type of prosthesis (eye, penile, other), artificial heart valve, eyelid spring or wire, artificial or prosthetic limb, metallic stent, filter or coil, shunt (spinal or intraventricular), vascular access port and/or catheter, radiation seeds or implants, Swan-Ganz or thermodilution catheter, medication patch (nicotine, nitroglycerine, other), any metallic fragment or foreign body, wire mesh implant, tissue expander (breast or other), surgical staples, clips or metallic sutures, joint replacement (hip, knee, other); bone/joint pin, screw, nail, wire, plate, other; IUD, diaphragm or pessary; dentures or partial plates; tattoo or permanent makeup, body piercing jewelry, hearing aid (remove before entering MRI room), other implant, have you ever done any welding?, breathing problems or motion disorder, claustrophobia; are you, or is there a possibility you are pregnant?

I attest that the information on this form is correct to the best of my knowledge. I read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form.

Signature of person completing form Date

Print name Relationship to patient

Form completed by: Patient Relative Technologist