PATIENT SCREENING & QUESTIONNAIRE

Patient Name: ______________________ DOB:______________ Age: ________ Weight: ________ Sex: M F

Please bring any related x-rays or scans you have with you. They will be used for comparison.

Have you ever had an injury to your eyes involving metal? ☐ YES ☐ NO
Could you possibly be pregnant? ☐ YES ☐ NO
Are you breast feeding? ☐ YES ☐ NO
Do you have body piercings? ☐ YES ☐ NO
If yes, where? ______________________
Do you have a medication patch? (e.g. nitroglycerine, nicotine) ☐ YES ☐ NO
If yes, where? ______________________
Do you have a history of kidney disease, asthma, or other allergic respiratory disease? ☐ YES ☐ NO
If yes, please describe: ______________________
Have you ever had an MRI exam before and had a problem? ☐ YES ☐ NO
If yes, please describe: ______________________
Do you have a history of renal disease? ☐ YES ☐ NO
If yes, when and where was your last blood work done? ______________________
Have you ever had a kidney removed? ☐ YES ☐ NO
Are you on dialysis? ☐ YES ☐ NO
If yes, when are you scheduled to be dialyzed again? ______________________
Do you have a history of liver disease or failure? ☐ YES ☐ NO
Have you had, or are you scheduled to have, a liver transplant? ☐ YES ☐ NO
If yes, when and where? ______________________

Please mark yes or no — Have you ever had...

☐ Y ☐ N	ear implants	☐ Y ☐ N	spine surgery	☐ Y ☐ N	aneurysm repair / clips
☐ Y ☐ N	penile implant	☐ Y ☐ N	seizure activity	☐ Y ☐ N	permanent makeup or tattoos
☐ Y ☐ N	history of cancer	☐ Y ☐ N	artificial joints	☐ Y ☐ N	pacemaker / cardiac defibrillator
☐ Y ☐ N	claustrophobia	☐ Y ☐ N	IV infusion pumps	☐ Y ☐ N	bone pins or plates
☐ Y ☐ N	anxiety attacks	☐ Y ☐ N	bullets or shrapnel	☐ Y ☐ N	heart valves replaced
☐ Y ☐ N	brain surgery	☐ Y ☐ N	MRI contrast reaction	☐ Y ☐ N	removable dental work
☐ Y ☐ N	neurostimulator	☐ Y ☐ N	implanted drug pump (e.g. insulin, baclofen, chemotherapy, pain medicine)		

Please list all previous surgeries and their approximate dates:

Date	Type of Surgery	Date	Type of Surgery
•		•	
•		•	
•		•	
•		•	
•		•	

INSTRUCTIONS FOR THE PATIENT

1. You are urged to use the ear plugs or headphones that we supply for use during your MRI examination since some patients may find the noise levels uncomfortable
2. Remove all jewelry (e.g. necklaces, pins, rings, earrings, etc.).
3. Remove all hair pins, bobby pins, barrettes, hair clips, etc.
4. Remove all dentures, false teeth or partial dental plates.
5. Remove hearing aids.
6. Remove eyeglasses.
7. Remove your watch, pager, cell phone, credit and bank cards, and all other cards with a magnetic strip.
8. Remove body piercing objects.
9. Remove all clothing with metal fasteners, zippers, etc. A gown will be provided if necessary.

We encourage you to contact us at 703.478.0922 with any questions you may have about this form or your procedure.

Consent: I understand the accuracy of this screening is essential to my safety in the MRI environment and that MRI is contraindicated in some instances. Frequently a contrast agent needs to be used with the MRI scanning process. Magnevist and Optimark are FDA approved for MRI. However, patients who are pregnant, breast feeding, have sickle cell anemia, or have severe renal impairment should inform the technologist prior to the scanning procedure.

I, the undersigned, or parent/ legal guardian (if under 18) have read and understand the above, and have provided the necessary information to the best of my knowledge.

______________________ ______________________

Patient or Legal Guardian Date Witness Date

Please complete and bring with you to your appointment. Thank you!

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