Name: _____ Phone No.: _____

Date: _____ DOB: _____ Height: ___ft. ___in Weight: _____ lbs EGFR: _____ Date: _____

BODY PART: _____ ❑ Left ❑ Right ❑ N/A

Drug/Other Allergies: _____

Please indicate if you have any of the following:

❑ **YES** ❑ **NO** **Cardiac Pacemaker, Pacemaker Wires, Implanted Cardiac Defibrillator (ICD) If YES, stop and alert staff**

❑ **YES** ❑ **NO** **Heart Valve Prosthesis or Loop Recorder: Make / Model / Date:** _____

❑ **YES** ❑ **NO** **Brain Aneurysm Clip(s) Make/Model/Date:** _____

❑ **YES** ❑ **NO** **Shunt / Filters / Intravascular Coil / Vascular Clips: Make / Model / Date:** _____

❑ **YES** ❑ **NO** **Stents #____ Type: ❑ Coronary ❑ Other Make / Model / Date** _____

❑ **YES** ❑ **NO** **Vascular access port or catheters (Swan Ganz for inpatients)?** _____

❑ **YES** ❑ **NO** **Have you EVER had an Eye Injury Involving Metal? (Slivers, shavings, foreign body, etc). If yes, was the metal removed by a doctor?** _____

❑ **YES** ❑ **NO** **Eye Surgery / Implants / Spring / Wires / Retinal Tack:** _____

❑ **YES** ❑ **NO** **Ear Surgery / Cochlear Implant / Stapes Prosthesis / Implant** _____

❑ **YES** ❑ **NO** **Hearing aids / removable dental work?** _____

❑ **YES** ❑ **NO** **Orthopedic Pins / Plates / Screws / Rods / Joints / Prosthesis / Etc:** _____
If yes, List: _____

❑ **YES** ❑ **NO** **Any Metal Fragments / Bullets / BBs / Shrapnel:** _____

❑ **YES** ❑ **NO** **Electronic Implant / Neurostimulator / Biostimulator / Spinal Cord or Bone Growth Stimulator?**
Make / Model _____ **If removed, where / when** _____

❑ **YES** ❑ **NO** **Tissue Expander (e.g., breast)** _____

❑ **YES** ❑ **NO** **Implanted Drug Infusion Device / Insulin Pump / Glucose Monitor?** _____

❑ **YES** ❑ **NO** **Other Electrical / Mechanical / Magnetic Implants? Type** _____

❑ **YES** ❑ **NO** **Any Type of Prosthesis (eye, penile, limb, etc): Make / Model** _____

❑ **YES** ❑ **NO** **Have you had an Endoscopy or Colonoscopy within the Last Year?** _____
If yes, was a clip / device placed or did you swallow a pill camera _____

❑ **YES** ❑ **NO** **Tattoos / Permanent Makeup / body piercing?:** _____

❑ **YES** ❑ **NO** **External monitoring devices? Cardiac monitor or ankle monitor?** _____

❑ **YES** ❑ **NO** **Do you wear any Medication Patches? (e.g., Nicotine / Nitro / etc) type / location:** _____

❑ **YES** ❑ **NO** **Any Other Metal or Implants Not Listed Above?** _____

❑ **YES** ❑ **NO** **IUD, Diaphragm, or Pessary:** _____

❑ **YES** ❑ **NO** **Pregnant / Possibility of Pregnancy / breast feeding?** _____

❑ **YES** ❑ **NO** **Are you Claustrophobic? Has your doctor given you any Medication to help you relax? ❑ yes or ❑ no**
If medicated, a ride to / from your MRI exam is needed.

❑ **YES** ❑ **NO** **Previous Surgery on Area Being Scanned Today? List Surgery Type & Dates:** _____

❑ **YES** ❑ **NO** **Prior surgery to any body part? List type / date** _____

❑ **YES** ❑ **NO** **Any Invasive procedures or surgeries in the last 6 weeks?** _____

❑ **YES** ❑ **NO** **Have you had a previous MRI? When: _____ Where: _____ Body part:** _____

❑ **YES** ❑ **NO** **Have you ever had an allergy to contrast injected for an MRI or CT?** _____

❑ **YES** ❑ **NO** **Personal History of Cancer? When:_____ Type:** _____

❑ **YES** ❑ **NO** **Are you diabetic, have renal insufficiency or any renal disease/dialysis?** _____

❑ **YES** ❑ **NO** **Do you have difficulty with IV Access?** _____

_____ _____

Patient/Parent/Legal Guardian Signature **Date/Time**

Staff Use Only

Final screening completed:

_____ _____ _____ _____

Patient/Parent/Legal Guardian Signature **Date/Time** **MRI Technologist Signature** **Date/Time**

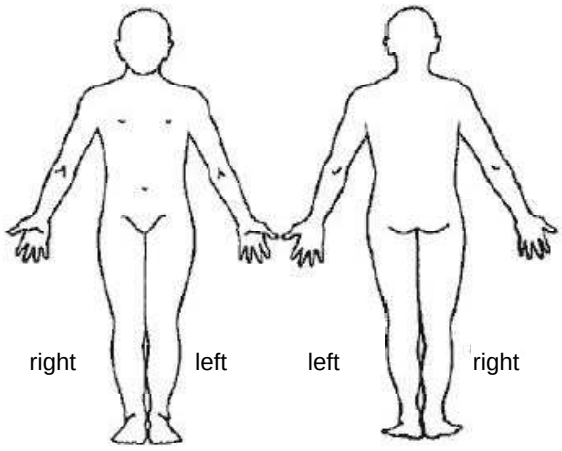
Please remove <u>all</u> metallic objects before the MRI, including: hearing aide(s), dentures, body piercings, keys, hairpins, barrettes, jewelry, watch, safety pins, paperclips, money clips, credit cards, coins, belts, pens, and pocketknives.

How long have you had these symptoms?_____

Are these symptoms a result of an accident or injury? (please check) ❑ Yes ❑ No

Please check the symptoms that apply to your MRI visit and describe if applicable

❑ Redness
❑ Pain
❑ Lump or swelling
❑ Mass
❑ Clicking
❑ Grinding
❑ Locking
❑ Limited Motion
❑ Stiffness
❑ Numbness: (please check) ❑ Right ❑ Left ❑ Arm ❑ Leg
❑ Tingling: (please check) ❑ Right ❑ Left ❑ Arm ❑ Leg
❑ Weakness: (please check) ❑ Right ❑ Left ❑ Arm ❑ Leg
❑ Loss of Bowel/Bladder Control
❑ Headaches
❑ Seizures
❑ Dizziness
❑ Slurred Speech
❑ Memory loss
❑ Confusion
❑ Double vision: (please check) ❑ Right ❑ Left
❑ Hearing Loss: (please check) ❑ Right ❑ Left
❑ Ringing in ear: (please check) ❑ Right ❑ Left
❑ None of the above



<u>PLEASE SHADE IN AREA OF PAIN</u>

<u>Technologist's Notes</u>

Please make sure to tell your technologist all of the symptoms that brought you here today.

Sign below if you have answered all above questions to the best of your knowledge.

_____ _____
Signature of Patient or Responsible Party Date / Time

_____
Relationship to Patient

_____ _____
Reviewed by Date / Time

If there are questions regarding the MRI safety screener please contact MRI at 603−740−2660 <u>OR</u> Imaging Scheduling at 603−740−2588 option #1.
For In−patients only, please fax the completed form to MRI 603−740−3329.