RADIOLOGY ASSOCIATES OF ALBUQUERQUE, PA *SERVING YOU SINCE 1971*

PATIENT HISTORY AND SCREENING FORM

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☐ **Albuquerque Imaging Center**
Office # 505-243-4401 Fax #505-243-6474

☐ **High Resolution**
Office # 505-332-5800 Fax # 505-332-5801

Patient Name _____ ☐ Male ☐ Female SS No. _____

Date of Birth _____ Age _____ Height _____ Weight _____

Best number to be reached on during the day: _____ ☐ Cell ☐ Home ☐ Work

Follow-up Doctor's Name _____ Next Appointment _____

List any other physician you would like the report sent to: _____

_____

What symptoms are you having that the MRI is ordered for? _____

Describe your pain: if any (e.g. burning, sharp, constant) _____ How Long? _____

Does the pain involve any other body part? If yes, where? _____ ☐ Left ☐ Right

Do you have numbness? ☐ Yes ☐ No If yes, where? _____ What side? ☐ Left ☐ Right

Do you have weakness? ☐ Yes ☐ No If yes, where? _____ What side? ☐ Left ☐ Right

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

Have you had any **surgery in the area being scanned today?** ☐ **Yes** ☐ **No** **If yes, what was done?**

_____

The facility name where the surgery was performed and date? _____

Have you had any heart, brain or ear surgery? ☐ Yes ☐ No If yes, what was done? _____

_____

Please list any other health problems you may have including a history of cancer, high blood pressure or diabetes:

_____

Have you ever been given I.V. dye or contrast for an exam? ☐ Yes ☐ No If yes, did you have any problems from the injection? _____

Are you on oxygen? ☐ Yes ☐ No If yes, how many liters? ____ Do you have any Medication allergies? _____

PLEASE CIRCLE A RESPONSE ON EACH OF THE FOLLOWING

Yes No Aneurysm Clips

Yes No Cardiac Pacemaker or implanted cardioverter defibrillator

Yes No Have you ever had metal in your eyes?

Yes No Are you on dialysis?

Yes No Are you, or is there a possibility that you are pregnant? *(If you are pregnant, your physician must call our radiologist for an approval to perform the MRI)*

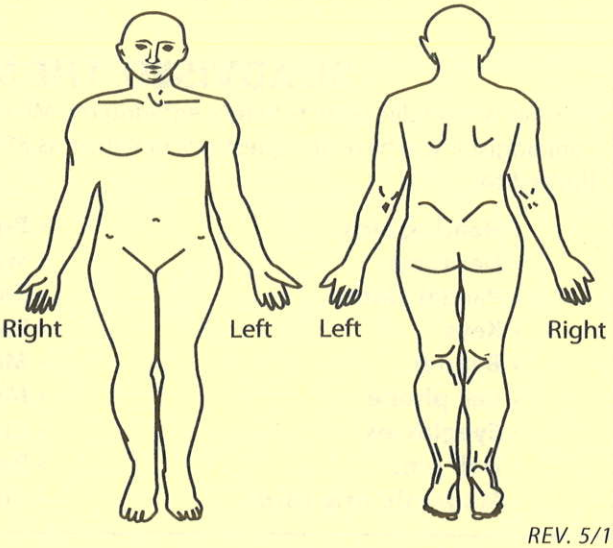
Yes No Are you breastfeeding? *(If you are having a contrast exam, please speak with the technologist)*

Yes No Artificial heart valve

Yes No Metallic stent, filter or coil

Yes No Insulin pump, infusion pump, or implanted drug infusion device?

Please mark the location of any pain.



REV. 5/14

Yes No **Joint replacement** *(e.g. hip, knee, other)* what body part? _____ when? _____

Yes No **Surgical staples, clips or metallic sutures**

Yes No **Do you have a bone/joint pin, screw, nail, wire, plate, or bone growth fusion stimulator?** *(If yes, please circle which one)*

Yes No **Cochlear, otologic or other ear implant**

Yes No **Eyelid spring or wire**

Yes No **Internal electrodes, wire, or electronic implant, or magnetically activated device**

Yes No **Neurostimulation system or Spinal cord stimulator**

Yes No **Prosthetic limb** *(If yes, which body part?* _____ *)*

Yes No **Any type of prosthesis** *(e.g. eye, penile, other)*

Yes No **Do you have a shunt? If yes, please circle which one: Spinal Intraventricular Programmable**

Yes No **Vascular access port and/or catheter or Swan Ganz or thermodilution catheter**

Yes No **Radiation seeds or implants**

Yes No **Medication patch** *(e.g. nicotine or nitroglycerin)*

Yes No **Wire mesh implant**

Yes No **Tissue expander** *(breast or other)*

Yes No **IUD, diaphragm, or pessary**

Yes No **Dentures or partial plates**

Yes No **Hearing aid** *(Remove before entering the MRI room)*

Yes No **Any metallic fragment or foreign body not surgically implanted or bullet or bullet fragment**

Yes No **Other implant**

If you have a tattoo you might feel a slight warming or tingling sensation. Please let the technologist know if you experience any discomfort.

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

Signature of person completing the form _____ Date _____

Relationship to patient _____

(Must be over 18 years of age to sign)

IMPORTANT INSTRUCTIONS

The MR system has a strong magnetic field that may be hazardous to individuals entering into the MR environment with mechanical devices or objects. Therefore, **ALL** individuals are required to fill out this form **BEFORE** entering the MR environment or MR system room.

BE ADVISED, THE MR SYSTEM MAGNET IS ALWAYS ON.

Remove all metallic objects before entering the MR environment or MR system room. Please consult the MRI Technologist or Radiologist if you have any questions or concerns BEFORE you enter the MR system room. **Metallic objects include by are not limited to:**

- **Hearing aids**
- **Dentures**
- **Partial plates**
- **Keys**
- **Beeper**
- **Cell phone**
- **Eyeglasses**
- **Hair pins**
- **Magnetic strip cards**
- **Body piercing jewelry**
- **Watch**
- **Safety pins**
- **Paper clips**
- **Money**
- **Money clip**
- **Credit cards**
- **Bank cards**
- **Zippers**
- **Pens**
- **Pocket Knife**
- **Nail Clippers**
- **Tools**
- **Metal clothing fasteners**
- **Clothing w/metallic threads**
- **Coins**
- **Jewelry**