

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: \_\_\_\_\_

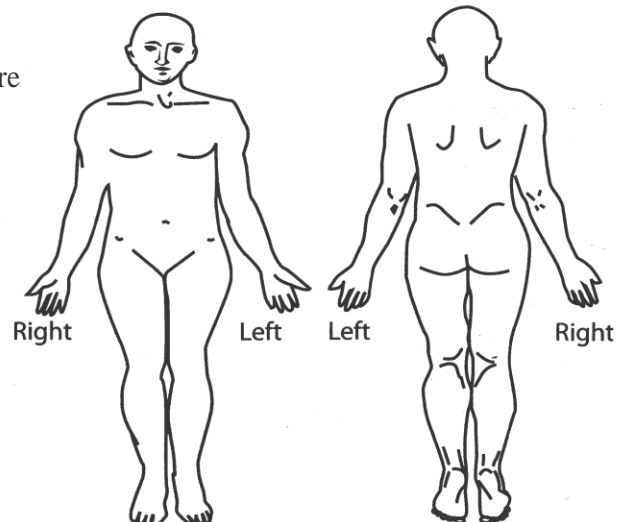
Have you ever been given I.V. dye or contrast for an exam?  Yes  No If yes, did you have any problems from the injection? \_\_\_\_\_

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 defibrillator
- Yes No Have you ever had metal in your eyes?
- Yes No FreeStyle Libre glucose monitor (Must be removed before MRI)
- Yes No Wearing Colored Contacts (Must be removed before MRI)
- Yes No Neulasta OnPro? (Must be removed before MRI)
- Yes No Are you, or is there a possibility that you are pregnant?
- Yes No Are you breastfeeding?
- Yes No Are you on dialysis?
- Yes No Artificial heart valve
- Yes No Insulin pump, infusion pump, or implanted drug infusion device?

Please mark the location of any pain.



- Yes No **Breast tissue expander for reconstruction** (Not breast implants)
- Yes No **Stent, filter, or coil**
- 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?**
- 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 **Any type of prosthesis** (e.g. eye, penile, limb, or 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. pain, nicotine, or nitroglycerin)
- Yes No **Diaphragm or pessary**
- Yes No **Dentures or partial plates**
- Yes No **Hearing aid** (Must be removed 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         | • Body piercing jewelry | • Pens                        |
| • Dentures             | • Watch                 | • Pocket Knife                |
| • Partial plates       | • Safety pins           | • Nail Clippers               |
| • Keys                 | • Paper clips           | • Tools                       |
| • Beeper               | • Money                 | • Metal clothing fasteners    |
| • Cell phone           | • Money clip            | • Clothing w/metallic threads |
| • Eyeglasses           | • Credit cards          | • Coins                       |
| • Hair pins            | • Bank cards            | • Jewelry                     |
| • Magnetic strip cards | • Zippers               |                               |