RADIOLOGY ASSOCIATES OF ALBUQUERQUE, PA SERVING YOU SINCE 1971

PATIENT HISTORY AND SCREENING FORM

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HIGH RESOLUTION Office 505-332-5800 Fax 505-332-5801

Safety of all individuals in the MRI environment is of upmost importance. Therefore, all individuals entering the MR environment are required to fill out this form for their safety. If you have any questions about anything on this form please ask to speak with an MRI technologist.

Patient Name _____ ☐ Male ☐ Female ☐ Non-binary SS No._____

Date of Birth_____ Age_____ Height_____ Weight (required)_____

Best number to be reached at during the day_____ ☐ Cell ☐ Home ☐ Work

Emergency Contact Name_____ Number_____ Relationship_____

Other than your ordering physician, please list any other physicians you would like to receive a copy of the report

_____

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

How long have you been having these symptoms? _____

Describe your pain if any (e.g. burning, sharp, constant) _____

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

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

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

Have you had any prior X-rays, CT scans, Bone scans, PET scans, or MRI scans **of the area being scanned today?**

☐ **Yes** ☐ **No** **If yes, where and when?** _____

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

_____

What is the name of the facility where the surgery was performed? _____

Have you ever had any heart, brain, or ear surgery? ☐ Yes ☐ No If yes, what was done and at what facility?

_____

Please list any health problems you may have including any 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? _____

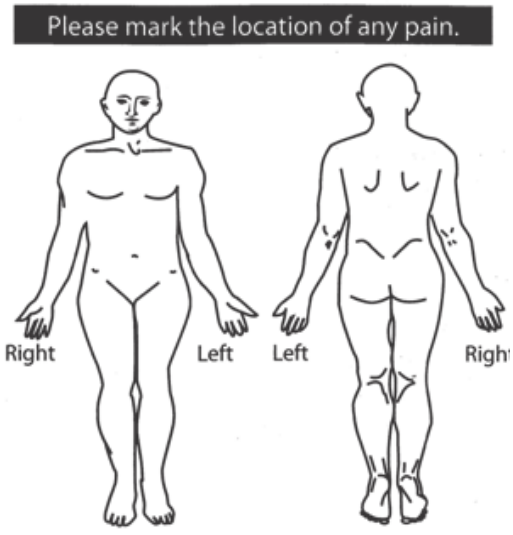
Please list any allergies to medications, adhesives, or latex? _____

PLEASE CIRCLE A RESPONSE FOR EACH OF THE FOLLOWING

Yes No Aneurysm Clip(s)
Yes No Cardiac Pacemaker or Implanted Defibrillator
Yes No Have you ever had metal in your eyes?
Yes No Continuous Glucose Monitor *(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 Insulin pump or infusion pump
Yes No Implanted Drug Infusion Device
Yes No Wearing Colored Contacts *(Must be removed before MRI)*
Yes No Wearing magnetic eyelashes *(Must be removed before MRI)*
Yes No Artificial heart valve *If yes, what type, brand, and implant date?*

_____

Yes No Neurostimulator system
Yes No Spinal Cord Stimulator
Yes No Hearing aid *(Must be removed before entering the MRI room)*
Yes No Stent, filter, or coil



Please see reverse side

Yes No Implanted cardiac rhythm monitor or heart loop recorder
Yes No Breast tissue expander for reconstruction *(Not breast implants)*
Yes No Joint Replacement *(e.g. hip, knee, other) If yes, what body part?*_____ *Implant Date:*_____
Yes No Surgical staples, clips, or metallic sutures
Yes No Bone/joint pin, screw, nail, wire, or plate? *If yes, where?*_____ *Implant Date:*_____
Yes No Bone growth fusion stimulator
Yes No Cochlear, otologic, or other ear implant
Yes No Eyelid spring or wire
Yes No Are you on dialysis?
Yes No Internal electrodes, wire, electronic implant, or magnetically activated device
Yes No Any type of prosthesis (*e.g. eye, penile, limb, or other)* _____
Yes No Shunt *if yes, please circle which one* **Spinal Intraventricular Programmable**
Yes No Vascular access port and/or catheter
Yes No Swan Ganz or thermodilution catheter
Yes No Radiation seeds or implants
Yes No Medication patch *(e.g. pain, nicotine, nitroglycerine, or other)*
Yes No Diaphragm or pessary
Yes No Dentures or partial plates *(any dentures or partials with exposed metal must be removed prior to the MRI)*
Yes No Wearing clothing with copper or other metallic threading in the material *(Must be removed before MRI)*
Yes No Wearing magnetic nail polish
Yes No Metallic fragment or foreign body not surgically implanted *(e.g. bullet, BB, bullet fragment, shrapnel, etc.)*
Yes No Other implant *if yes, please list:*_____

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

By signing below I attest that 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. (Must be over 18 years of age to sign)

Signature of person completing the form_____ **Date:** _____

Relationship to patient_____

IMPORTANT INSTRUCTIONS
BE ADVISED, THE MR SYSTEM MAGNET IS ALWAYS ON!

Remove all removable metallic objects before entering the MR environment. Please consult the MRI Technologist or Radiologist if you have any questions or concerns BEFORE you enter the MR system room. You will be provided a locker to securely lock up your belonging during the MRI. **Metallic objects include but are not limited to:**

- **Hearing aids**
- **Watches**
- **Hair pins**
- **Paper clips**
- **Money clip**
- **Credit cards**
- **Nail Clippers**
- **Bra w/ hooks, clips, or underwire**
- **Body Piercing jewelry**
- **Pocket knife**
- **Clothes w/ metallic threads**
- **Medical alert button**
- **Eyeglasses**
- **Bank cards**
- **Metal clothing fasteners**
- **Dentures w/ metal**
- **Gun**
- **Safety pins**
- **Beeper**
- **Medical alert button**
- **Magnetic strip cards**
- **Clothes w/ shoulder adjusters**
- **Partial plate**
- **Jewelry**
- **Tools**
- **Cell phone**
- **Coins**
- **Zippers**
- **Keys**