

# MRI CHEST, ABDOMEN, PELVIS PATIENT HISTORY AND SCREENING

Name: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

Please explain your present complaint or problem in detail \_\_\_\_\_  
\_\_\_\_\_

How long have you had this problem? \_\_\_\_\_

Any previous injury or surgery to this area?  Yes  No

If yes, please explain \_\_\_\_\_

Do you have a history of cancer?  Yes  No

If yes, please explain \_\_\_\_\_

When was it diagnosed? \_\_\_\_\_

Have you had any previous studies of the body part being scanned today?  Yes  No

If yes, type of study? \_\_\_\_\_

Where and when? \_\_\_\_\_

Do you have a history of renal or liver disease?  Yes  No

Are you on dialysis?  Yes  No

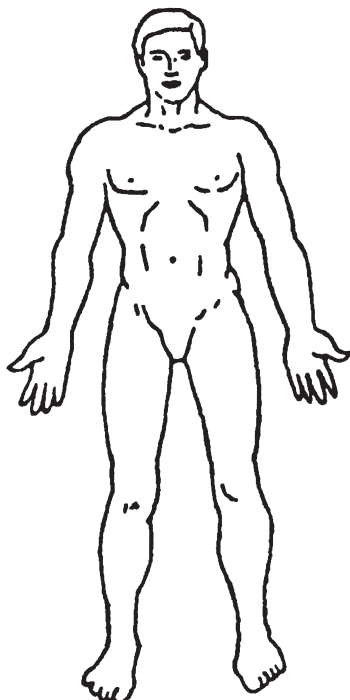
Are you a diabetic?  Yes  No

Do you have high blood pressure?  Yes  No

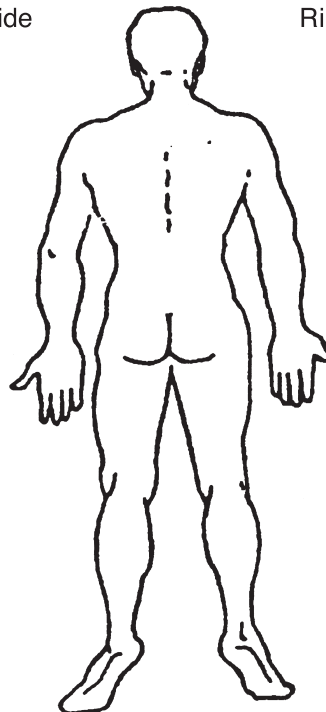
Are you on diabetes meds?  Yes  No

Are you on HTN meds?  Yes  No

FRONT  
Right Side Left Side



BACK  
Left Side Right Side



(please turn over)

# PATIENT MRI SAFETY SCREENING FORM

Name \_\_\_\_\_ Weight \_\_\_\_\_

Date of Birth \_\_\_\_\_ Last menstrual period \_\_\_\_\_  N/A

Please check any that apply:

Possibly pregnant?  Yes Claustrophobic (afraid of closed in areas)?  Yes

Have you **EVER** worked around metal grinding/filing or welding?  Yes

Have you **EVER** had metal particles in your eyes?  Yes

Please list any surgeries you have had \_\_\_\_\_

*Please list any known allergies to latex, tape or drugs that you have:* \_\_\_\_\_

**Do you have history of renal disease or dialysis?**  No  Yes

The following items **can** interfere with MR imaging and **can** be hazardous to your safety. Please check appropriate items & notify the Technologist if you have any of the following:

_____ Cardiac pacemaker	_____ Hearing aids	_____ Brain clips
_____ Cochlear implants	_____ Aortic clips	_____ Shunts
_____ Carotid clips	_____ Joint replacements	_____ Neurostimulators (Tens)
_____ Harrington rod	_____ Heart valve replacements	_____ Bone or joint pins
_____ Insulin pump	_____ Prosthesis	_____ Electrodes
_____ Wire sutures	_____ Metal mesh	_____ Shrapnel
_____ Metal plates	_____ Dental/teeth work with magnets	_____ Stents
	_____ Therapeutic Magnets or screws, nails or metal rods	
_____ Other (please list) _____		

***DO NOT ENTER THE SCANNING ROOM WITH ANY OF THE FOLLOWING ITEMS:***

Hearing aids, Magnetic strip cards (credit cards, bank cards), Jewelry, Hairpins/barrettes, Glasses, Watch, Wallet/Money Clip, Pocketknife, Safety pins, Pens/pencils, Phone/pager, Keys, Coins

***\* Lockers will be provided to lock patient valuables \****

I have reviewed and confirmed that the above information is complete to the best of my knowledge:

**Pt. Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

***Please turn form over for additional information***

MRI Technologist has interviewed patient: \_\_\_\_\_ Tech