



MRI CHEST, ABDOMEN, PELVIS PATIENT HISTORY AND SCREENING

Name: _____ Referring Physician: _____

Please explain your present complaint or problem in detail: _____

How would you describe your pain? No pain
 crampy dull sharp constant comes and goes

How long have you had this problem? _____

Any previous injury or surgery to this area? No Yes

If yes, please explain: _____

Do you have a personal history of cancer? No Yes

If yes, what type of cancer? _____

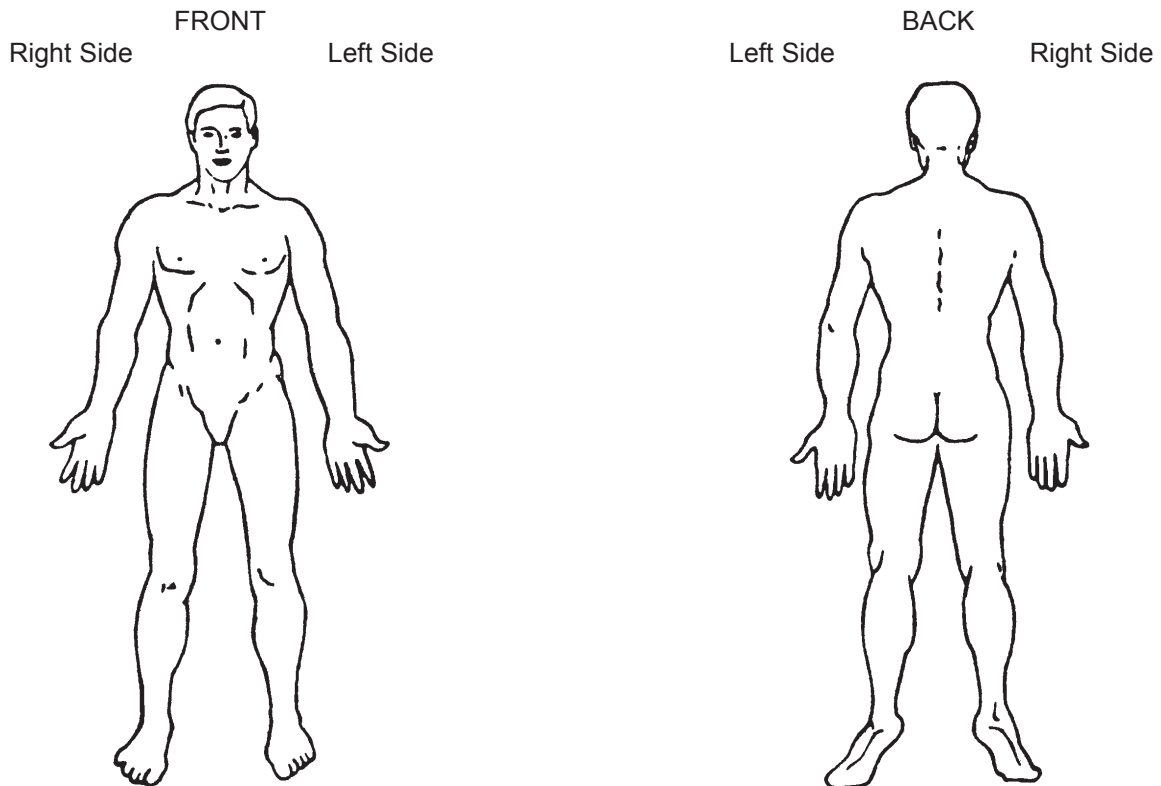
When was it diagnosed or found? _____

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

If yes, type of study? _____

Where and when? _____

Please circle/shade the area where you are having problems on the picture below:



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:

Please list current medications : _____

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

Do you have history of High Blood Pressure? No Yes

Do you have history of diabetes? No Yes

Do you have Sickle Cell? No Yes

Do you have history of liver disease? No Yes

Do you have history of asthma? 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	
_____ Medication patch	_____ 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, Pocket knife, 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

IV angiocath started: _____ RN/Tech

IV angiocath has been D/C: _____ RN/Tech