Print Reset Form

BAPTIST M&S IMAGING

Name: _____

Date of Birth: _____Last 4 numbers of SS#: _____Height: _____Weight: _____

MAGNETIC RESONANCE (MRI) PROCEDURE SCRENING FORM/GENERAL QUESTIONAIRE

WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure. **DO NOT ENTER** the MR system room or MR environment if you have any question or concern regarding an implant, device, or object. The **MR MAGNET IS ALWAYS ON**. The noise level of the MRI machine is considerable. Normally the earplugs are sufficient. If you would also like to use headphones (not allowed on all procedures), please inform the technologist. **IMPORTANT INSTRUCTIONS:** before entering the MR environment or MR system room, you must remove all metallic objects including hearing aids, dentures, partial plates, keys, beeper, cell phone, eyeglasses, hair pins, barrettes, jewelry, body piercing, watch, safety pins, paperclips, money clip, credit cards, banks cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools, clothing with metal fasteners, and clothing with metallic threads. **PLEASE CONSULT THE MRI TECHNOLOGIST OR RADIOLOGIST IF YOU HAVE ANY QUESTIONS OR CONCERNS BEFORE YOU ENTER THE MRI SYSTEM ROOM.**

1. Reason for MRI and symptoms: _____
   ☐Headaches☐Pain☐Numbness☐Other: _____
   How long have you had this problem? _____ Symptoms worse:☐Left ☐Right
2. Prior Studies: Have you have any previous imaging studies of that part being examined today? ☐Yes☐No
   Where: _____ When: _____
   Type of Exam: ☐X-Ray☐CT☐MRI☐Ultrasound☐Nuclear Medicine☐PET
3. Have you had any major surgeries?☐Yes ☐No Where: _____ When: _____
   ☐Heart☐Back/neck ☐Gall Bladder☐Uterus ☐Appendix☐Other _____
4. Medical History (check all that apply) : First date of last menstrual period: _____
   ☐Diabetes ☐High Blood Pressure☐Smoking ☐Kidney Disease☐Asthma/COPD
   ☐Cancer – personal history (specify type): _____
   ☐Cancer – family history (specify type): _____
5. Have you ever had an allergic reaction to IV contrast material used in an imaging procedure (Iodine or Gadolinium)?
   ☐Yes☐ No: Please explain _____
6. Allergy to latex? ☐Yes☐No
7. Are you pregnant, or is there a chance you may be pregnant? ☐Yes ☐No ☐ N/A. **If Yes, please speak to your technologist.**
8. Are you currently breastfeeding?☐Yes ☐No ☐ N/A **(If Yes, you MAY discard breast milk for 24 hrs.)**
   If you have questions please speak with your MRI technologist.
9. Have you had an injury to the eye involving a metallic object or fragment (e.g. bullet, shrapnel, metallic slivers, shaving, foreign body, sheet metal work, welding, etc.? If yes, please explain _____
10. Are you currently taking any muscle relaxers or sedative? ☐Yes ☐No If yes, please explain:_____

Please indicate if you have any of the following: **If any of the marked (asterisk) apply, please notify staff immediately**

☐Yes☐No * Aneurysm Clips/Coils
☐Yes☐No * Cardiac Pacemaker
☐Yes☐No * Implanted Cardioverter Defibrillator/ICD
☐Yes☐No * Electronic Implant or device
☐Yes☐No * Magnetically – activated implant/device
☐Yes☐No * Spinal Cord Stimulator
☐Yes☐No Claustrophobia
☐Yes☐No Medication patch (Nicotine, Nitroglycerine)
☐Yes☐No Wire mesh implant
☐Yes☐No Tissue expander (breast, etc.)
☐Yes☐No Surgical staples, clips, or metallic sutures
☐Yes☐No Joint replacement (hip, knee, etc.)
☐Yes☐No Bone/joint pin, screw, nail, wire, plate, etc.
☐Yes☐No IUD, diaphragm, pessary
☐Yes☐No Bone growth/bone fusion stimulator
☐Yes☐No Cochlear, otologic, or other ear implant

☐Yes☐No Implanted drug infusion device (Pain or Insulin)
☐Yes☐No Any type of prosthesis (eye, penile, etc.)
☐Yes☐No Heart valve prosthesis
☐Yes☐No Eyelid spring or wire
☐Yes☐No Artificial or prosthetic limb
☐Yes☐No Metallic stent, filter, or Coil
☐Yes☐No Shunt (spinal or intraventricular)
☐Yes☐No Dentures or partial plates
☐Yes☐No Body piercing jewelry
☐Yes☐No Hearing aid (Remove before entering room)
☐Yes☐No Breathing or motion disorder
☐Yes☐No Vascular access port and/or catheter
☐Yes☐No Radiation seeds or implants
☐Yes☐No Swan-Ganz or thermodilution catheter
☐Yes☐No Other implant _____

I attest that the above information is correct to the best of my knowledge. I have read and understand the contents of this form and have had the opportunity to ask questions regarding the information on this form and the MR procedure that I am about to undergo.

Signature of person completing the form: _____ _____ Date ____/___/____

Reviewed by (Technologist Name): _____ _____ Date ____/___/____

Reviewed by: _____ _____ Date ____/___/____