MRI BRAIN
PATIENT HISTORY AND SCREENING

Name: ______________________________ Referring Physician: ____________________________

Please explain your present complaint or problem in detail ________________________________

____

How long have you had this problem? ____

Please check all of the following symptoms you have:

_____ Pain	_____ Confusion	_____ Difficulty walking		
_____ Fainting	_____ Depression	_____ Difficulty talking		
_____ Tremors	_____ Vision Problem	_____ Numbness	❑ Rt.	❑ Lt.
_____ Nausea	_____ Hearing Loss	_____ Weakness	❑ Rt.	❑ Lt.

Do you take medication for high blood pressure? ❑ No ❑ Yes

Have you had any of the following:

Head injury? ❑ No ❑ Yes If so, when? ____

Did you lose consciousness? ____

Head surgery? ❑ No ❑ Yes If so, when and why? ____________________________________

Do you have a shunt? ❑ No ❑ Yes If so, how long have you had it? ____________________

Carotid artery surgery? ❑ No ❑ Yes If so, when and where? _________________________

Do you have personal history of cancer? ❑ No ❑ Yes

If so, do you know what kind? ____

Radiation therapy to your head? ❑ No ❑ Yes

When? ____

Are you right handed? ❑ Yes Left handed? ❑ Yes

Previous MRI or CT of your head? ❑ No ❑ Yes

If so, when and where? ____

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