

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

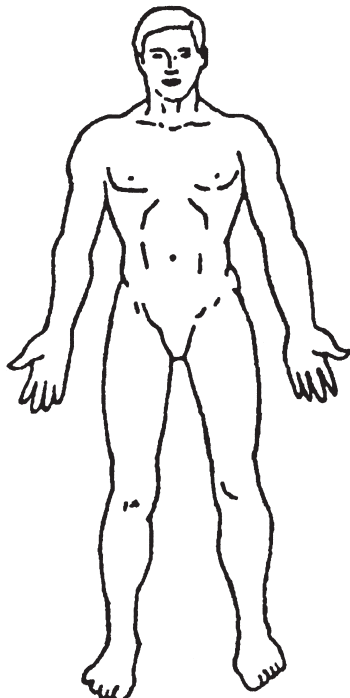
Are you a diabetic? ☐ Yes ☐ No

Are you on diabetes meds? ☐ Yes ☐ No

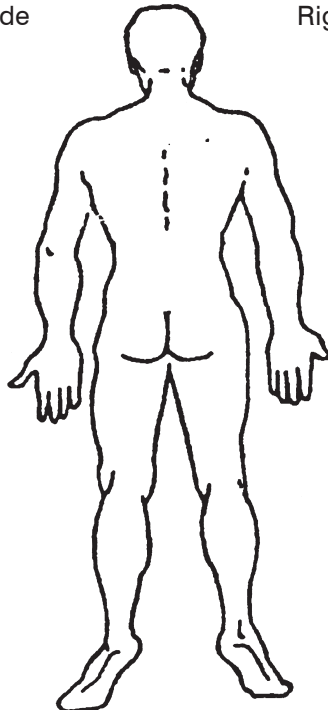
Do you have high blood pressure? ☐ Yes ☐ No

Are you on hypertension meds? ☐ Yes ☐ No

FRONT
Right Side Left Side



BACK
Left Side Right Side



(please turn over)



NAME: _____

DOB: _____

WEIGHT: _____ lbs. _____

The following items may be harmful to you during your MRI Scan or may interfere with the MRI examination. You must provide a “**yes**” or “**no**” for every item. Please indicate if you have, or have had any of the following:

* SIGNATURE:	YES	NO
Any type of electronic, mechanical, or magnetic implant: ear (otologic, cochlear, or other ear implant), penile, or other If yes, type: _____	☐	☐
Cardiac pacemaker, defibrillator or other cardiac implant (in place or removed)	☐	☐
Aneurysm clip	☐	☐
Artificial heart valve	☐	☐
Neurostimulator / biostimulator (e.g., spinal cord or brain stimulator) If yes, type _____	☐	☐
Any type of internal electrodes or wires	☐	☐
Hearing aid	☐	☐
Implanted drug pump (e.g., insulin, baclofen, chemotherapy, pain medicine)	☐	☐
Medication patch (e.g., nitroglycerin, nicotine)	☐	☐
Spinal fixation device (e.g., Halo Vest)	☐	☐
Spinal fusion procedure	☐	☐
Any type of coil, filter, or stent If yes, where and what type? _____	☐	☐
Any type of metal object (e.g., shrapnel, bullet, BB, metal fragment, or foreign body)	☐	☐
Bone growth / bone fusion stimulator	☐	☐
Shunt (spinal or intra-ventricular)	☐	☐
Eye surgery (e.g., eyelid springs, scleral buckle, cataracts, cornea transplant, or other eye implant)	☐	☐
Any type of surgical clip or staple	☐	☐
Any IV access port (e.g., Broviac, Port-a-Cath, Hickman, PICC line)	☐	☐
Endoscopy or Colonoscopy in the last 30 days? If yes, when? _____	☐	☐
Prosthesis (artificial limb, joint, or eye) If yes, location: _____	☐	☐
Tissue expander (e.g., breast)	☐	☐
Removable dentures, false teeth or partial plate	☐	☐
Diaphragm, IUD, pessary If yes, type: _____	☐	☐
Surgical mesh If yes, location _____	☐	☐
Body piercing, including dermal (under the skin) If yes, location _____	☐	☐
Permanent makeup (tattoos or tattooed eyeliner)	☐	☐
Radiation seeds (e.g., cancer treatment)	☐	☐
Bone / joint pins, rods, screws, nails, plates, wires, spinal fusion, etc. If yes, location: _____	☐	☐
Tracking device (such as an ankle bracelet provided by law enforcement)	☐	☐



TECHNOLOGIST: _____

MR99082 (11/21)