

MAGNETIC RESONANCE (MR) PROCEDURE SCREENING FORM FOR PATIENTS

Date ____/____/____

Patient Number _____

Name _____ Age _____ Height _____ Weight _____
Last name First name Middle Initial

Date of Birth ____/____/____ Male Female Body Part to be Examined
month day year

Are you certain about if you have had prior surgery or injury of any kind? No Yes

If you are not certain you do not need to fill out the following

1. Have you had prior surgery or an operation (e.g., arthroscopy, endoscopy, etc.) of any kind? No Yes
If yes, please indicate the date and type of surgery:
Date ____/____/____ Type of surgery _____
Date ____/____/____ Type of surgery _____
Date ____/____/____ Type of surgery _____
Date ____/____/____ Type of surgery _____
Date ____/____/____ Type of surgery _____
Date ____/____/____ Type of surgery _____
Date ____/____/____ Type of surgery _____
2. Have you experienced any problem related to a previous MRI examination or MR procedure? No Yes
If yes, please describe: _____
3. Have you had an injury to the eye involving a metallic object or fragment (e.g., metallic slivers, shavings, foreign body, etc.)? No Yes
If yes, please describe: _____
4. Have you ever been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel, etc.)? No Yes
If yes, please describe: _____
5. Are you currently taking or have you recently taken any medication or drug? No Yes
If yes, please list: _____
6. Are you allergic to any medication? No Yes
If yes, please list: _____
7. Do you have a history of asthma, allergic reaction, respiratory disease, or reaction to a contrast medium or dye used for an MRI, CT, or X-ray examination? No Yes
8. Do you have anemia or any disease(s) that affects your blood, a history of renal (kidney) disease, or seizures? No Yes
If yes, please describe: _____

For female patients:

9. Post menopausal? No Yes
10. Are you pregnant or experiencing a late menstrual period? No Yes
11. Are you currently breastfeeding? No Yes

