



**Quakerbridge Radiology Associates  
PRE-MRI SCREENING FORM**

Name \_\_\_\_\_ Referring Doctor \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Work/Cell (\_\_\_\_) \_\_\_\_\_ Study Ordered \_\_\_\_\_

What is the Reason for Study? Explain medical problem in detail? (What is problem? Where is problem? Etc.)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

1. Have you ever had surgery or any similar invasive procedure?  No  Yes

If yes, please list:

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Type: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Type: \_\_\_\_\_

2. Have you had any previous studies?  No  Yes

If yes, please list:

	<u>Body Part</u>	<u>Date</u>	<u>Facility Location</u>
<b>MRI</b>	_____	____/____/____	_____
<b>CT/CAT</b>	_____	____/____/____	_____
<b>X-Ray</b>	_____	____/____/____	_____
<b>Ultrasound</b>	_____	____/____/____	_____
<b>Nuclear Medicine</b>	_____	____/____/____	_____
<b>Other</b>	_____	____/____/____	_____

**3. Please answer Yes or No to the questions below:**

- Yes  No Do you take heart medication? If yes, name(s) of medication(s) \_\_\_\_\_
- Yes  No Do you have history of cancer?
- Yes  No Have you had anything ever removed from your eyes?
- Yes  No Do you have history of brain or heart surgery?
- Yes  No Pregnant or experiencing a late menstrual period? **Date of last menstrual period** \_\_\_\_/\_\_\_\_/\_\_\_\_
- Yes  No Are you breast feeding?
- Yes  No Are you taking any type of fertility medication or having fertility treatments?
- Yes  No Are you taking oral contraceptives or receiving hormone treatment?
- Yes  No Are you taking any medications, please list: \_\_\_\_\_
- Yes  No Do you have anemia or any diseases that affect your blood?
- Yes  No Do you have history of Renal disease?
- Yes  No Do you have history of Hypertension?
- Yes  No Do you have history of Seizures?
- Yes  N Do you have history of Diabetes
- Yes  No Worked around metal (grinding, lathes, welding) or injury to eye involving a metallic object (e.g., metallic slivers, shavings, foreign body)? if yes, please describe: \_\_\_\_\_

4. Do you have drug allergies please describe? \_\_\_\_\_  No  Yes

5. Have you ever had asthma, allergic reaction, respiratory disease, or other reaction to a contrast medium or dye used for an MRI or CT examination, if yes, please describe? \_\_\_\_\_  No  Yes

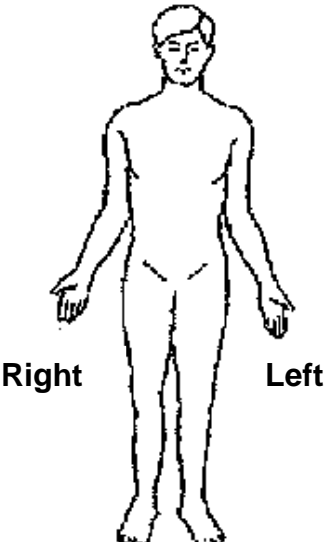
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6. Some of the following items may be hazardous to your safety and interfere with the MRI examination.  
Please check the correct answer for each of the following.

Do you have any of the following?

- |                              |                             |  |
|------------------------------|-----------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Cardiac pacemaker                          |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Implanted cardiac defibrillator            |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Aneurysm clip(s)                           |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Carotid artery vascular clamp              |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Neurostimulator                            |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Insulin or infusion pump                   |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Implanted drug infusion device             |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Bone growth/fusion stimulator              |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Cochlear, otologic, or ear implant         |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Any type of prosthesis (eye, penile, etc.) |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Heart valve prosthesis                     |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Artificial limb or joint                   |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Electrodes (on body, head, or brain)       |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Intravascular stents, filters, or coils    |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Shunt (spinal or intraventricular)         |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Vascular access port and/or catheter       |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Swan-Ganz catheter                         |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Any implant held in place by a magnet      |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Transdermal delivery system (Nitro)        |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | IUD or diaphragm                           |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tattooed makeup (eyeliner, lips, etc.)     |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Body piercing(s)                           |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Any metal fragments                        |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Internal pacing wires                      |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Aortic clip                                |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Metal or wire mesh implants                |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Wire sutures or surgical staples           |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Harrington rods (spine)                    |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Metal rods in bones                        |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Joint replacement _____                    |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Bone/joint pin, screw, nail, wire, plate   |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hearing aid ( <b>Remove before MRI</b> )   |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Dentures ( <b>Remove before MRI</b> )      |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Breathing disorder                         |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Motion disorder                            |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Claustrophobia                             |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Anxiety                                    |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Other, please explain: _____               |

Please mark on the figure below the location of any implant or metal inside of or on your body.



**! IMPORTANT!**

Before your MRI, please remove all metallic objects including keys, hair pins, barrettes, jewelry, watch, safety pins, paperclips, money clip, credit cards, coins, pens, belt, metal buttons, pocket knife and clothing with metal in the material.

**NOTE: YOU ARE REQUIRED TO WEAR EARPLUGS OR EARPHONES DURING THE MRI EXAMINATION**

Signature of Person Completed Form \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Form Completed By:  Patient  Relative  Physician or other \_\_\_\_\_  
Signature  
Name /Relationship to Patient

**To be completed by the MRI Facility:** Medical record number: \_\_\_\_\_ Completed by: \_\_\_\_\_

Procedure: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

Clinical History: \_\_\_\_\_

Contrast Amount (cc): \_\_\_\_\_ Lot #: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_