

## Envision Imaging of Frisco PATIENT HISTORY AND SCREENING FORM FOR MRI

Patient Name: \_\_\_\_\_ Sex:  M  F Weight \_\_\_\_\_ AGE \_\_\_\_\_

Clinical History: Please explain your medical problems that are the reason for having an MRI today: \_\_\_\_\_

FOR SPINE EXAMS: ANY ARM OR LEG PAIN?  RIGHT  LEFT  NONE

Have you had any previous X-ray, MRI or CAT scans related to this problem: YES  NO

WHERE and WHEN were previous scans performed? \_\_\_\_\_

### DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS OR ITEMS IN YOUR BODY?

Paceaker.....	Yes	No
Ear/Cochlear Implant/Hearing aid .....	Yes	No
Brain/Aneurysm Clips.....	Yes	No
Do you have any kidney disease.....	Yes	No
Metal in eyes or ever had any removed.....	Yes	No
Metal fragments or shrapnel.....	Yes	No
Implanted electrical device.....	Yes	No
Neurostimulators.....	Yes	No
Stents or Heart valve.....	Yes	No
Dentures (with metal) .....	Yes	No
Penile Implant.....	Yes	No
Tattoos/Permanent Make-up.....	Yes	No
Transdermal Patches (pain, smoking).....	Yes	No
Body piercings.....	Yes	No
Any other metal object or implants.....	Yes	No
Are you diabetic.....	Yes	No
Do you have any liver disease.....	Yes	No
Have you ever had a liver transplant.....	Yes	No
Do you have hypertension.....	Yes	No
Do you have a history of cancer.....	Yes	No
If yes, what kind? _____		

<b>CONTRAST</b>		
_____ CC's	Contrast _____	
Lot # _____	Exp Date _____	
Tech _____	Rad _____	
BUN _____	CREAT _____	GFR _____

List previous surgeries: \_\_\_\_\_

Other problems: Please explain \_\_\_\_\_

**Female Patients only:**

Is there any possibility of pregnancy..... Yes No

Are you currently breast-feeding..... Yes No

When was the *first* day of your last menstrual cycle? \_\_\_\_\_

What birth-control method are you currently using? \_\_\_\_\_

**I have answered these questions to the best of my knowledge and understand the information presented to me.**

Patient/Parent/Legal Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Technologist \_\_\_\_\_