smartscan MEDICAL IMAGING LLC

MRI PATIENT HISTORY SCREENING FORM

Date: _____ **Patient ID:** _____
(Office Use Only)

Patient Name: _____ **Referring MD:** _____

Date of Birth: _____ **Height**: _____ **Weight:** _____ ☐ **Male** ☐ **Female**

Body Part to be Examined: _____

Reason for MRI and/or Symptoms

_____
_____
_____

1. Have you had a prior surgery or an operation on the area being scanned ? ☐ **No** ☐ **Yes**
If yes: Date _____/_____/_____ Type of surgery: _____

2. Have you had a prior diagnostic imaging study or examination on the area being scanned (MRI, CT, Ultrasound, X-ray)?
☐ **No** ☐ **Yes** If yes, please describe: _____

3. Are you allergic to any medication?
☐ **No** ☐ **Yes** If yes, please list: _____

4. Do you have a history of allergic reaction to a contrast medium or dye used for a MRI? ☐ **No** ☐ **Yes**

5. Do you have hypertension (high blood pressure) or diabetes? ☐ **No** ☐ **Yes**

6. Do you personally have a history of any type of cancer? (Not a family history)
☐ **No** ☐ **Yes** If yes, what type? _____

7. Do you have history of renal (kidney) disease, dialysis or cancer or lupus? ☐ **No** ☐ **Yes** If yes, patient's GFR _____
For Office Use Only:

For Female Patients Only:

8. Are you pregnant or experiencing a late menstrual period? ☐ **No** ☐ **Yes**

9. Are you currently breastfeeding? ☐ **No** ☐ **Yes**

10. Are you taking any type of fertility medication or having fertility treatments? ☐ **No** ☐ **Yes**
If yes, please describe: _____

X_____ _____
Patient Signature (or Authorized Representative and Relationship) Date

Technologist Notes:

_____
_____
_____

Patient Name:_____ DOB:_____ MRN: _____

Smart Scan Medical Imaging: Patient MRI Safety Screening Form

☐ No	☐ Yes	Aneurysm clip(s), coils(s) or shunt(s)
☐ No	☐ Yes	Cardiac pacemaker and or Defibrillator (ICD)
☐ No	☐ Yes	Recent iron injections
☐ No	☐ Yes	Magnetically activated device
☐ No	☐ Yes	Neurostimulator system
☐ No	☐ Yes	Internal electrodes or wires
☐ No	☐ Yes	Cochlear or other ear implant
☐ No	☐ Yes	Insulin/drug infusion or Glucose monitor device
☐ No	☐ Yes	Heart valve prosthesis or aortic clips
☐ No	☐ Yes	Eyelid spring, wire or implanted device
☐ No	☐ Yes	Artificial/ Prosthetic Limb or Penile
☐ No	☐ Yes	Metallic stent, filter or coil
☐ No	☐ Yes	Metal fragments including bullets, shrapnel or BB's
☐ No	☐ Yes	Vascular access port and/or catheter
☐ No	☐ Yes	Radiation seeds or implants, Radiation port
☐ No	☐ Yes	Swan-Ganz or thermodilution catheter
☐ No	☐ Yes	Medication patch
☐ No	☐ Yes	Any metallic fragment or foreign body to the eyes
☐ No	☐ Yes	Do you work with metal (cutting, grinding, welding metal)
☐ No	☐ Yes	Surgical staples, clips, metal sutures
☐ No	☐ Yes	Gastric camera
☐ No	☐ Yes	Bone/joint replacement/pins/screws
☐ No	☐ Yes	Tissue expander (e.g., breast)
☐ No	☐ Yes	Dentures or partial plates/ expanders or temporary devices
☐ No	☐ Yes	Recent Tattoo(s) or permanent make-up
☐ No	☐ Yes	Body piercing jewelry, Dermal piercings (Remove prior to MRI)
☐ No	☐ Yes	Breathing problem or motion disorder
☐ No	☐ Yes	Hearing aids (Remove before entering MRI room)
☐ No	☐ Yes	Any other Implants
☐ No	☐ Yes	Colonoscopy clips/ or Endoscopy pill cam
☐ No	☐ Yes	Claustrophobia Medicine needed?
☐ No	☐ Yes	Do you need any special assistance? (wheelchair, oxygen, translator etc.?)

_____ _____

Patient Signature (or Authorized Representative and Relationship) Date

Technologist Initials:_____