

**SOUTH DENVER IMAGING
PATIENT HISTORY AND SCREENING FORM FOR MRI**

Patient Name: _____ Date: _____ Sex: M F Weight _____
 DOB: _____ Referring Physician _____
 Clinical History: Please explain your medical problems that are the reason for having an MRI today: _____

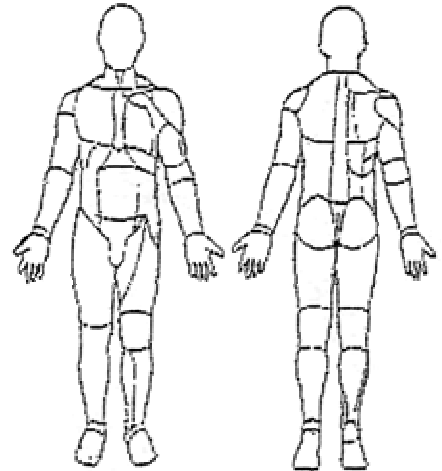
FOR SPINE EXAMS: ANY ARM OR LEG PAIN? (RIGHT) (LEFT) (NONE)
FOR TECHNOLOGIST TO COMPLETE:

 Previous X-ray, MRI or CAT Scan: YES[] NO[] _____

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

- | | | |
|-------------------------------------------|-----|----|
| Pacemaker | Yes | No |
| Ear/Cochlear Implant | | |
| Or hearing aids | Yes | No |
| Brain/Aneurysm Clips | Yes | No |
| Metal in eyes or ever | Yes | No |
| Had any removed | | |
| Metal fragments or | Yes | No |
| Shrapnel | | |
| Implanted electrical device | Yes | No |
| Neurostimulators | Yes | No |
| Stents | Yes | No |
| Dentures held in with magnets | Yes | No |
| Tattoos/Permanent Make-up | Yes | No |
| Body piercings | | |
| Any other metal objects or implants _____ | | |
| List previous | | |
| Surgeries _____ | | |

PLEASE INDICATE
ANY AREAS OF PAIN



- | | | |
|--------------------------------------------------------|-----|----|
| Have you ever had an injection of contrast for an MRI? | Yes | No |
| If yes, did you experience any of the following: | | |
| Hives | Yes | No |
| Shortness of breath | Yes | No |
| Other problems | | |
| Explain _____ | | |

FEMALE PATIENTS

- | | | |
|---------------------------------------|-----|----|
| Is there any possibility of pregnancy | Yes | No |
| Are you currently breast-feeding | Yes | No |

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/Witness Signature _____