SISKIYOUimaging

MRI Screening/History Form

Name_____ Date_____

Date of birth _____ Age _____Weight_____ Chart #_____

Body part to be Examined _____ Reason for MRI and / or symptoms_____

Date of next appt _____ Referring physician _____ Telephone _____

Fax _____

Please answer these questions regarding your medical history.

1. Tumors or Cancer? Y N Type _____ TX _____ When _____
2. Neurological Disease? Y N Seizure / Stroke / Alzheimer / Parkinson / Multiple Sclerosis / Other _____
   (Please circle)
3. Have you ever had a problem with Bleeding / Blood clots / Anemia? (Please circle)
4. Do you have: Renal (kidney) disease Y N Cardiac (heart) disease Y N Diabetes Y N
   High Blood Pressure Y N Thyroid diseases Y N Other _____
5. Have you had any injury to the eye involving a metallic object or fragment (e.g. metallic slivers, shavings)? Y N
   If yes, explain: _____ Was it removed?_____
6. Have you ever been injured by a metallic object or foreign body (e.g. BB, Bullet, Shrapnel, etc)? Y N
   If yes, explain: _____ Was it removed? _____
7. Are you currently taking or have you recently taken any medication or drug? Y N
   If yes, list: _____
8. Are you allergic to any medication? Y N Latex? Y N
   If yes, list: _____
9. Do you have a history of asthma, allergic reaction, respiratory disease, or reaction to a contrast media used for an MRI , CT or X-ray exam?
   Y N (please explain reaction) _____
10. Are you pregnant or experiencing a late menstrual period?
    Y N N/A Last menstrual cycle ___/___/___
11. Are you having fertility treatments? Y N Are you currently breastfeeding? Y N
12. Are you claustrophobic? Y N If medicated, medication name, strength, time taken _____

Please indicate if you have any of the following:

- ☐ Yes ☐ No Aneurysm clips
- ☐ Yes ☐ No Implanted Cardioverter Defibrillator (ICD)
- ☐ Yes ☐ No Magnetically-activated implant or device
- ☐ Yes ☐ No Spinal cord stimulator
- ☐ Yes ☐ No Bone growth/bone fusion stimulator
- ☐ Yes ☐ No Insulin or other Infusion Pump
- ☐ Yes ☐ No Heart Valve Prosthesis
- ☐ Yes ☐ No Shunt (spinal or intra-ventricular)
- ☐ Yes ☐ No Radiation seeds or implants
- ☐ Yes ☐ No Any metallic fragment or foreign body
- ☐ Yes ☐ No Surgical staples, clips, or metallic sutures
- ☐ Yes ☐ No Bone/joint pin, screw, nail, wire, plate, etc.
- ☐ Yes ☐ No Any prosthesis (eye, penile, limb etc.)
- ☐ Yes ☐ No Tattoo or permanent make-up
- ☐ Yes ☐ No Eyelid spring or wire
- ☐ Yes ☐ No Other implant _____
- ☐ Yes ☐ No Cardiac pacemaker
- ☐ Yes ☐ No Electronic implant or device
- ☐ Yes ☐ No Neurostimulation system
- ☐ Yes ☐ No Internal electrodes or wires
- ☐ Yes ☐ No Cochlear, otologic, or other ear implant
- ☐ Yes ☐ No Implanted drug infusion device
- ☐ Yes ☐ No Metallic stent, filter, or coil
- ☐ Yes ☐ No Vascular access port and/or catheter
- ☐ Yes ☐ No Medication patch (Nicotine, Nitroglycerine)
- ☐ Yes ☐ No Tissue expander (e.g., breast)
- ☐ Yes ☐ No Joint replacement (hip, knee, etc.)
- ☐ Yes ☐ No IUD, diaphragm, or pessary
- ☐ Yes ☐ No Dentures or partial plates
- ☐ Yes ☐ No Body piercing jewelry
- ☐ Yes ☐ No Hearing aid

(Remove before entering MR system room)

278 Maple Street • Ashland, OR 97520 • Phone: 541-201-4500 • Fax: 541-488-7529 • www.siskiyouimaging.com
A partnership of Ashland Community Hospital, Rogue Valley Medical Center and Southern Oregon Radiology Associates.

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IMPORTANT INSTRUCTIONS: Before entering the MR environment or MR system room, you must remove all metallic objects including hearing aids, dentures, partial plates, keys, beeper, cell phone, eyeglasses, hair pins, barrettes, jewelry, body piercing, watch, safety pins, paper clips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools, clothing with metal fasteners, & clothing with metallic threads.

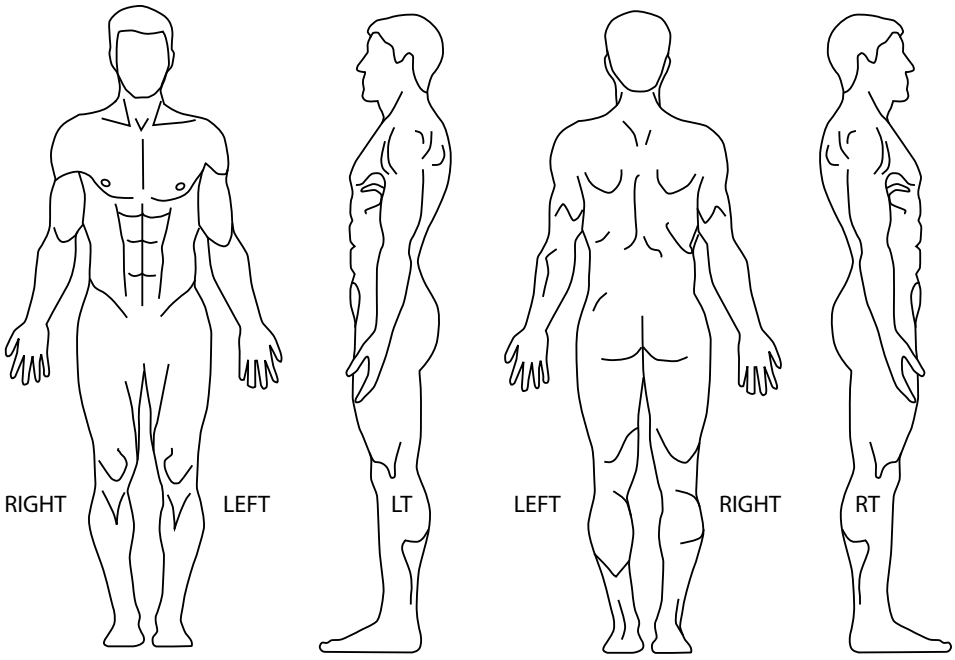
Please consult the MRI Technologist or Radiologist if you have any questions or concerns **BEFORE** you enter the MR system room.

NOTE: You may be advised or required to wear earplugs or other hearing protection during the MR procedure to prevent possible problems or hazards related to acoustic noise.

WHERE ARE YOUR SYMPTOMS?

Please write these letters USING RED INK on the diagram below:

X = Where you hurt the most A = Aching B = Burning N = Numbness P = "Pins and Needles" S = "Stabbing" W= Weakness



I attest that the above information is correct to the best of my knowledge. I read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and regarding the MR procedure that I am about to undergo.

Signature of Person Completing Form: _____ Date ____/____/____
Signature

Form Completed By: ☐ Patient ☐ Relative ☐ Nurse _____ _____
Print Name Relationship to Patient

Form Information Reviewed By: _____ _____
Print Name Signature

☐ MRI Technologist ☐ Nurse ☐ Radiologist ☐ Other _____

WARNING: Certain Implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure (i.e., MRI, MR Angiography, functional MRI, MR Spectroscopy). DO NOT ENTER the MR system room or MR environment if you have any questions or concerns regarding an implant, device, or object. Consult the MRI Technologist or Radiologist BEFORE entering the MR system room. The MR system magnet is always on.

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