Date: ____/____/____ Patient Number: _____

Name: _____ Age: _____ Height: _____ Weight: _____
Last name First name Middle Initial

Date of Birth: ____/____/____ Male ❑ Female ❑ Body Part to be Examined: _____
month day year

Address: _____ Telephone (home): (____) _____ - _____

City: _____ Telephone (work): (____) _____ - _____

State: _____ Zip Code: _____

Reason for MRI and/or Symptoms: _____

Referring Physician: _____ Telephone: (____) _____ - _____

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1. Have you had prior surgery or an operation (e.g., anthroscopy, endoscopy, etc.) of any kind? ❑ No ❑ Yes
   If Yes, please indicate the date and type of surgery:
   Date: ____/____/____ Type of surgery: _____
   Date: ____/____/____ Type of surgery: _____
2. Have you had prior therapy for back pain? ❑ No ❑ Yes If yes, please specify: _____ Type _____ Date _____
3. Have you had a prior diagnostic imaging study or examination (MRI, CT, Ultrasound, X-ray, etc.)? ❑ No ❑ Yes

If yes, please list:	Body Parts	Date	Facility
MRI	_____	____/____/____	_____
CT/CAT Scan	_____	____/____/____	_____
X-Ray	_____	____/____/____	_____
Ultrasound	_____	____/____/____	_____
Nuclear Medicine	_____	____/____/____	_____
Other _____	_____	____/____/____	_____

4. Have you experienced any problem related to a previous MRI examination or MR procedure? ❑ No ❑ Yes
   If yes, please describe: _____
5. Have you had an injury to the eye involving a metallic object or fragment (e.g., metallic slivers, shavings, foreign body, etc.)? ❑ No ❑ Yes
   If yes, please describe: _____
6. Have you ever been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel, etc.)? ❑ No ❑ Yes
   If yes, please describe: _____
7. Are you currently taking or have you recently taken any medication or drug? ❑ No ❑ Yes
   If yes, please list: _____
8. Are you allergic to any medication? ❑ No ❑ Yes
   If yes, please list: _____
9. Do you have a history of asthma, allergic reaction, respiratory disease, or reaction to a contrast Medium or dye used for an MRI, CT, or X-ray examination? ❑ No ❑ Yes
10. Do you have anemia or any disease(s) that affects your blood, a history of renal (kidney) disease, diabetes, on dialysis, renal or liver transplant, or seizures? ❑ No ❑ Yes
    If yes, please describe: _____

For Female Patients:

11. Date of last menstrual period: ____/____/____ Post menopausal? ❑ No ❑ Yes
12. Are you pregnant or experiencing a late menstrual period? ❑ No ❑ Yes
13. Are you currently breast feeding? ❑ No ❑ Yes

MEMORIAL HERMANN

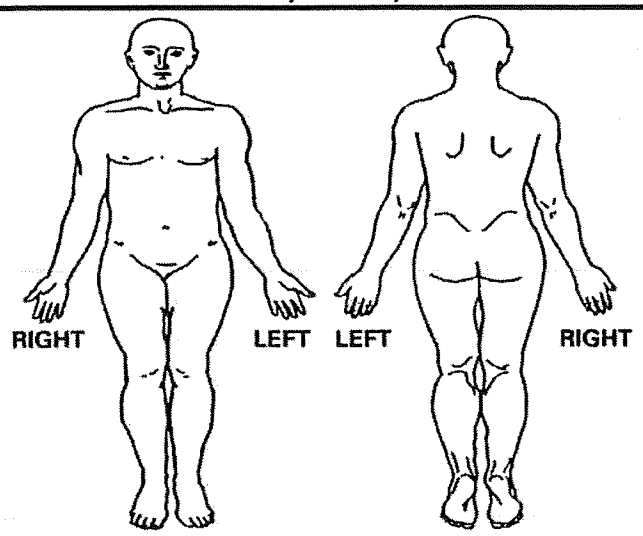
Magnetic Resonance (MR) Procedure Screening Form For Patients

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.**

Please indicate if you have any of the following:

- ❑ Yes ❑ No Claustrophobia
- ❑ Yes ❑ No Aneurysm clip(s)
- ❑ Yes ❑ No Any metallic fragment or foreign body (orbits)
- ❑ Yes ❑ No Any type of prosthesis (eye, penile, etc.)
- ❑ Yes ❑ No Artificial or prosthetic limb
- ❑ Yes ❑ No Body piercing jewelry
- ❑ Yes ❑ No Bone growth/bone fusion stimulator
- ❑ Yes ❑ No Bone/joint pin, screw, nail, wire, plate, etc.
- ❑ Yes ❑ No Breathing problem or motion disorder
- ❑ Yes ❑ No Cardiac pacemaker
- ❑ Yes ❑ No Cochlear, otologic, or other ear implant
- ❑ Yes ❑ No Dentures or partial plates
- ❑ Yes ❑ No Electronic implant device
- ❑ Yes ❑ No Eyelid spring or wire
- ❑ Yes ❑ No Hearing aid (Remove before entering MRI room)
- ❑ Yes ❑ No Heart valve prosthesis
- ❑ Yes ❑ No IUD, diaphragm, or pessary
- ❑ Yes ❑ No Implanted cardioverter defibrillator
- ❑ Yes ❑ No Implanted drug infusion device
- ❑ Yes ❑ No Insulin or other infusion pump
- ❑ Yes ❑ No Internal electrodes or wires
- ❑ Yes ❑ No Joint replacement (hip, knee, etc.)
- ❑ Yes ❑ No Magnetically-activated implant or device
- ❑ Yes ❑ No Medication patch (Nicotine, Nitroglycerine)
- ❑ Yes ❑ No Metallic stent, filter, or coil
- ❑ Yes ❑ No Neurostimulation system
- ❑ Yes ❑ No Other Implant _____
- ❑ Yes ❑ No Radiation seeds or implants
- ❑ Yes ❑ No Shunt (spinal or intraventricular)
- ❑ Yes ❑ No Spinal cord stimulator
- ❑ Yes ❑ No Surgical staples, clips, or metallic sutures
- ❑ Yes ❑ No Swan-Ganz or thermodilution catheter
- ❑ Yes ❑ No Tattoo or permanent makeup
- ❑ Yes ❑ No Tissue expander (e.g., breast)
- ❑ Yes ❑ No Vascular access port and/or catheter
- ❑ Yes ❑ No Wire mesh implant
- ❑ Yes ❑ No Combative or can not hold still for 30 minutes

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



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 jewelry, watch, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools, clothing with metal fasteners, and clothing with metallic threads.

Please consult the MRI Technologist or Radiologist if you have any question or concern BEFORE you enter the MR system room.

NOTE: Notify MRI immediately if yes to any of the above.

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.

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. If I am to have intravenous contrast with my MRI, I have been informed of the risks of possible allergic reactions and that patients with kidney disease can suffer serious to fatal effects by receiving gadolinium based contrast agents.

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 Date/Time

❑ MRI Technologist ❑ Nurse ❑ Radiologist ❑ Other: _____

MEMORIAL HERMANN

Magnetic Resonance (MR) Procedure Screening Form For Patients