

**COLORADO SPRINGS 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: _____		

Have you had a previous X-ray, MRI or CAT Scan relating to this problem? Yes No		
If Yes, what type of exam was done & name of facility that performed the exam: _____		

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

- | | | |
|-----------------------------|-----|----|
| Pacemaker | Yes | No |
| Ear/Cochlear Implant | Yes | No |
| Brain/Aneurysm Clips | Yes | No |
| Metal in eyes or ever | Yes | No |
| Had any removed | | |
| Metal fragments or Shrapnel | Yes | No |
| Implanted electrical device | Yes | No |
| Neurostimulators | Yes | No |
| Stents | Yes | No |
| Magnetic dental implants | Yes | No |
| Tattoos/Permanent Make-up | | |
| Body piercings | Yes | No |

Any other metal objects or implants _____

List previous Surgeries _____

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

Are you in renal failure or receiving dialysis? Yes No If yes, circle which one.

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 _____

Not applicable to this exam

_____ CC With a _____ @ _____ X _____			
Amount	GA & Needle Type	Time	# of punctures
In _____	Lot _____	Expiration Date: _____	
Site Location	By: _____		
Contrast Reaction	Yes	No	Physician Covering Contrast _____
Explain _____			