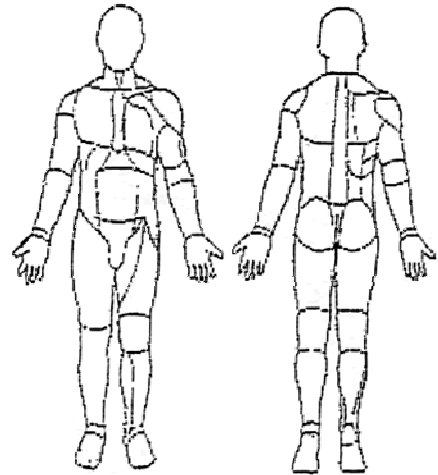


## COLORADO SPRINGS IMAGING PATIENT HISTORY AND SCREENING FORM FOR MRI

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<br>Had any removed | Yes | No |
| Metal fragments or<br>Shrapnel           | Yes | No |
| 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 \_\_\_\_\_
- |  |     |    |
|--|-----|----|
| 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 \_\_\_\_\_

Not applicable to this exam				
Amount	CC of Magnevist With a _____ @ _____	X _____	GA & Needle Type	Time
In _____	Lot _____	Expiration Date: _____	# of punctures	
Site Location	By: _____			
Contrast Reaction	Yes	No	Physician Covering Contrast _____	
Explain _____				