



MRI PATIENT SCREENING FORM

Height: _____ Weight: _____

What symptoms have prompted today's visit? _____

1) Cardiac pacemaker/Implanted Cardiovascular Defibrillator (ICD)/Heart valve/Heart surgery: Yes No

If yes, date/type _____

2) Shunts/Stents/Intravascular coil: If yes, date/type _____ Yes No

3) Ear or eye implants/surgery: If yes, date/type _____ Yes No

4) Injury to eye involving metal or metal shavings _____ Yes No

5) Brain surgery or aneurysm clips: If yes, date/type _____ Yes No

6) Any electrical, mechanical, magnetic pumps, stimulators, and/or implants? Yes No

If yes, date/type _____

7) Any body piercing jewelry? Yes No

8) Any breast tissue expanders? If yes, date/type _____ Yes No

9) Bullets, Shrapnel or metal fragments in skin or body? Yes No

If yes, specify _____

10) Dentures/Hearing aid/Wig: Please circle which applies Yes No

11) Any type of prosthesis (eye, penile, etc.)? If yes, date/type _____ Yes No

12) History of cancer or tumors Yes No

13) Please list anything you are allergic to: _____

14) Respiratory, liver, or blood disorders: If yes, specify _____ Yes No

15) Any metallic medication patches? If yes, specify _____ Yes No

16) Heart, Brain, Eye, or Ear surgery? If yes, date/type _____ Yes No

All other surgeries: _____ Date: _____

Please list dates and locations of prior MRI imaging related to today's exam:

_____ Date: _____

17) Age 60 or older? Yes No

18) History of high blood pressure requiring medication? Yes No

19) History of diabetes? Yes No

20) History of kidney disease including: Yes No

Dialysis Kidney Transplant Single Kidney Kidney Surgery History of Kidney Cancer

Patient or Guardian Signature: _____ Date: _____

VUI Tech initials: _____