VALLEY
Imaging Center

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) Are you breast feeding? Yes No

8) Any body piercing jewelry? Yes No

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

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

If yes, specify _____

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

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

13) History of cancer or tumors Yes No

14) Please list anything you are allergic to: _____

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

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

17) 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: _____

18) Age 60 or older? Yes No

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

20) History of diabetes? Yes No

21) History of renal disease including: Yes No

☐ Dialysis ☐ Kidney Transplant ☐ Single Kidney ☐ Kidney Surgery ☐ History of Kidney Cancer

Patient or Guardian Signature:_____ Date:_____

VUI Tech initials: _____