

MRI PATIENT HISTORY AND SCREENING FORM

Patient Name: Robert D Lutz Date: 05/17/2013
D.O.B: 07/26/1968 Age: 44 Weight: 215 Ht: 5' 11" Sex: M / F

Reason you are here today? Explain your medical problem in detail. (What is the problem? Where is the problem? Etc...)

3 Area Back MRI

Is your problem related to an injury? ☒ Yes ☐ No If yes, Date of injury? 01/25/2013
How were you injured? ☐ Work ☐ Motor Vehicle Accident ☐ Other
Have you taken any sedation/alcohol today to relax you for this procedure? ☒ Yes ☐ No If yes, what? Valium
If yes, do you have someone to drive you home? ☐ Yes ☐ No

Do you have or have you ever had any of the following?

- ☐ Yes ☒ No Cardiac Pacemaker
☐ Yes ☒ No Heart Surgery/Heart Valve: If Yes, explain: _____
☐ Yes ☒ No Implanted Cardiac Defibrillator (ICD): _____
☐ Yes ☒ No Brain Aneurysm Clips/ Brain Surgery: If Yes, explain: _____
☐ Yes ☒ No Shunts/Stents/Filters/Intravascular Coil: _____
☐ Yes ☒ No Eye Surgery/Implants/Spring/Wires/Retinal Tack: _____
☐ Yes ☒ No Injury to the Eye Involving Metal or Metal Shavings: _____
☐ Yes ☒ No Orthopedic Pins/Screws/Rods/Joints/Prosthesis: _____
☐ Yes ☒ No Neurostimulator/BioStimulator: _____
☐ Yes ☒ No History of Cancer or Tumors: When: _____ Where: _____
☐ Yes ☒ No Radiation Therapy/Chemo Therapy: _____
☐ Yes ☒ No Previous Back Surgery (Lumbar/Thoracic/Cervical): When: _____ Levels: _____
☐ Yes ☒ No Ear Surgery/Cochlear Implants/Hearing Aids/Stapes Prosthesis: _____
☐ Yes ☒ No Vascular Access Port/Catheter: _____
☐ Yes ☒ No Metal Mesh Implants/Wire Sutures/Wire Staples or Clips/Internal Electrodes: Hernia Operation
☐ Yes ☒ No Electrical/Mechanical/Magnetic Implants? Type: I don't think it
☐ Yes ☒ No Implanted Drug Infusion Pump/Insulin Pump: used Metal
☐ Yes ☒ No Are you Pregnant? When was your last Menstrual Period/Cycle? _____
☐ Yes ☒ No Tattoo's/Permanent Make-up/Body Piercing/Patches: _____
☐ Yes ☒ No Dentures/Partials/Dental Implants: _____
☐ Yes ☒ No Gunshot Wounds/Shrapnel/BB: _____
☐ Yes ☒ No Do you have pins in your Hair/Clothes/Hair Extensions/Hair Pieces/Wig: _____

List any Drug Allergies: _____

List Previous Surgeries: _____

List any Medications you're presently taking: _____

MRI Contrast History:

- ☐ Not applicable to this exam
Have you ever had MRI contrast? ☐ Yes ☐ No
Did you have any kind of reaction? ☐ Yes ☐ No If yes, explain: _____
Are you breast feeding at this time? ☐ Yes ☐ No
** Do you have any history of Renal disease? ☐ Yes ☐ No
** Do you have any history of Hypertension? ☐ Yes ☐ No
** Do you have any history of Diabetes? ☐ Yes ☐ No
** Have you ever had severe hepatic disease or liver transplant or pending liver transplant? ☐ Yes ☐ No

I attest that the above information is correct to the best of my knowledge. I have also informed the technologist that I am not pregnant at this time and I give consent to have a contrast agent administered to me if needed for proper diagnosis of my procedure. I acknowledge that I am aware of the possibility of side effects with contrast and I have had the opportunity to ask questions related to this form, to ask questions regarding the MRI procedure, and I understand the information presented to me.

X

Patient/Parent/Legal Guardian

MRI Technologist's Signature

Date

07/17/2013

FOR TECHNOLOGIST USE ONLY

Type of Contrast:

Contrast Temp:

Lot #:

Expiration Date:

Time of Injection:

Amount: