

Bright Light Radiology

**Magnetic Resonance Imaging (MRI)
Patient History/Screening Form**

Date:		Patient Name:	
Date of Birth:	Age:		
Referring Physician:		MD Phone:	

Briefly describe your symptoms and when they occur. (Please specify left or right, if appropriate)

Do you have a history or illness relating to your exam today? YES NO
If yes, what type of injury/illness and when did it occur?

Are you experiencing any pain? YES NO
If yes, where is the pain?

Are you experiencing any numbness? YES NO
If yes, where is the numbness?

Are you experiencing any tingling? YES NO
If yes, where is the tingling?

Are you experiencing any weakness? YES NO
If yes, where is the weakness?

Do you have headaches? YES NO
If yes, how many days/weeks/etc. has this been going on?

Do you experience dizziness? YES NO
If yes, how many days/weeks/etc. has this been going on?

Have you had prior surgery on the area to be scanned? YES NO
If yes, list date and type of surgery:

Do you have a history of cancer? YES NO
If yes, what type of cancer?

Have you had an MRI before? YES NO
If yes, list where and when the MRI was performed:

MARK THE DIAGRAM BELOW USING THE KEY:
P= Pain N= Numbness T= Tingling
S= Surgery W= Weakness

The diagram shows two human figures, one facing forward and one facing backward. Each figure has a box labeled 'R' (Right) and 'L' (Left) positioned near the hands. The front view has 'R' on the left side of the image and 'L' on the right side. The back view has 'L' on the left side of the image and 'R' on the right side. The figures are simple line drawings of a human torso and limbs.

Side Two

PLEASE FILL OUT OTHER SIDE

The following questions are to find out if you have anything in your body that may interfere with this exam. (If yes is indicated, please circle device or write the type next to the question.)

YES	NO	PLEASE CHECK APPROPRIATE BOX
<input type="checkbox"/>	<input type="checkbox"/>	Do you have a Cardiac Pacemaker or an Implanted Defibrillator? If yes, STOP here and notify the technologist.
<input type="checkbox"/>	<input type="checkbox"/>	Do you now or have you ever done cutting, grinding or polishing of metals on any high-speed grinder or tool? If yes, do you have a chance of having metal in your eyes? (Please tell the front desk immediately; an orbital x-ray may be needed.)
<input type="checkbox"/>	<input type="checkbox"/>	Metal clips in your body such as an aneurysm, hemostatic, brain, aortic, carotid, intraventricular shunts, etc.?
<input type="checkbox"/>	<input type="checkbox"/>	Metal dental materials such as braces, dentures, or wires?
<input type="checkbox"/>	<input type="checkbox"/>	Artificial heart valves?
<input type="checkbox"/>	<input type="checkbox"/>	Implants or prostheses: Eye or Ear implants (cochlear, stapes) , cataracts, penile, IUD, drug infusion pump, hearing aid, etc?
<input type="checkbox"/>	<input type="checkbox"/>	Neurostimulator or biostimulator (TENS unit)?
<input type="checkbox"/>	<input type="checkbox"/>	Implanted devices in your body, such as pins, rods, plates, screws, clips, surgical wires/staples?
<input type="checkbox"/>	<input type="checkbox"/>	Pregnant? Date of last menstrual period:
<input type="checkbox"/>	<input type="checkbox"/>	Breast feeding?
<input type="checkbox"/>	<input type="checkbox"/>	Claustrophobic?
<input type="checkbox"/>	<input type="checkbox"/>	Current problem with nausea or vomiting?
<input type="checkbox"/>	<input type="checkbox"/>	Allergies, asthma, renal disease, seizures, anemia, high blood pressure, irregular heart rate? <i>Please circle those that apply.</i>
<input type="checkbox"/>	<input type="checkbox"/>	Catheter such as Groshong, Quinton, Swan-Ganz, Hickman, Mediport.
<input type="checkbox"/>	<input type="checkbox"/>	Intravascular coil, filter, or stent, such as: Gianturco Coil, Gunther IVC filter, Palmaz Stent?
<input type="checkbox"/>	<input type="checkbox"/>	Surgery of any kind in the last 6 weeks?
<input type="checkbox"/>	<input type="checkbox"/>	Halo vest or metallic cervical fixation device?

**Please report any other metal or foreign body that you may have that is not listed above. If yes, tell receptionist as this may affect your scan.

IMPORTANT: Remove wallets, keys, credit cards, jewelry, watches, pocket knives, hair pins, wigs, pens/pencils, hearing aids, and dentures prior to going in to exam room. A locked dressing room is available for your convenience.

Patient Signature: _____

Date: _____

Technologist: _____

Date: _____