



**MRI SCREENING SHEET**

Patient Sticker  
Here please!

MRI BODY PART: \_\_\_\_\_

HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_

Do you have any of the following?	Yes	No
1. Metal slivers or rust in your eyes	<input type="checkbox"/>	<input type="checkbox"/>
2. Brain aneurysm clips	<input type="checkbox"/>	<input type="checkbox"/>
3. Ear implants (example: cochlea, stapes)	<input type="checkbox"/>	<input type="checkbox"/>
4. Hearing aids	<input type="checkbox"/>	<input type="checkbox"/>
5. Aortic valve clip	<input type="checkbox"/>	<input type="checkbox"/>
6. Cardiac pacemaker or mechanical heart valve	<input type="checkbox"/>	<input type="checkbox"/>
7. IUD (what type?) _____	<input type="checkbox"/>	<input type="checkbox"/>
8. Penile implant (what type?) _____	<input type="checkbox"/>	<input type="checkbox"/>
9. Joint replacement	<input type="checkbox"/>	<input type="checkbox"/>
10. Metal rods, plates, screws, nails, or clips	<input type="checkbox"/>	<input type="checkbox"/>
11. Body piercing or tattoos	<input type="checkbox"/>	<input type="checkbox"/>
12. Allergies to any medications	<input type="checkbox"/>	<input type="checkbox"/>
13. Claustrophobia	<input type="checkbox"/>	<input type="checkbox"/>
14. Surgery in the past 6 weeks (What kind?) _____	<input type="checkbox"/>	<input type="checkbox"/>
15. Are you pregnant? (duration) _____	<input type="checkbox"/>	<input type="checkbox"/>
16. Have you ever had an MRI before (what body part?) _____ (When/Where?) _____	<input type="checkbox"/>	<input type="checkbox"/>
17. Personal history of cancer	<input type="checkbox"/>	<input type="checkbox"/>
18. Heart stents When where they placed ? _____	<input type="checkbox"/>	<input type="checkbox"/>

Patient signature: \_\_\_\_\_

Tech signature: \_\_\_\_\_



## MRI Patient History

This form is your means of communication with our radiologist. The radiologist is the doctor who will be interpreting the MRI you will be having today. He will then communicate these results with YOUR physician via a faxed report. Although we strive here at FCI to get these reports to your physician within 24 hours, difficult cases sometimes necessitate further review and may take an additional 1-2 business days.

Please answer the following questions as thoroughly as possible. Although your physician may have an intimate knowledge and understanding of your particular case, the radiologist may not have all of this information. These answers will help ensure you receive an accurate diagnosis. Thank you!

a) What type of pain and/or symptoms are you experiencing? \_\_\_\_\_

---

---

---

b) How long have you been experiencing these symptoms? \_\_\_\_\_

---

---

c) Have you had an MRI for this specific problem before? \_\_\_\_\_

When? \_\_\_\_\_

Where? \_\_\_\_\_

d) Have you had any surgery to treat this problem? \_\_\_\_\_

When? \_\_\_\_\_

Where? \_\_\_\_\_

e) What other types of treatments have you had for this problem? \_\_\_\_\_

---

---

---