MADISON
Radiological Group

MRI Patient Screening Form

Name: _____

DOB: _____/_____/_____ Age: _____ F M

Medical History

Are you allergic to any medications?	Y	N	If yes, please list:		
Have you ever had a MRI?	Y	N	If yes, where was it performed:		
Have you ever had MRI contrast?	Y	N	If yes, did you have an allergic reaction to the contrast?	Y	N
Do you have a history of seizures?	Y	N	Do you have asthma or any type of respiratory disease?	Y	N
Have you ever been diagnosed with cancer?	Y	N	If yes, year diagnosed? Type of Cancer?		
Have you ever had multiple myeloma?	**Y**	**N**	**Do you have any type of kidney disease?**	**Y**	**N**
Are you diabetic?	**Y**	**N**	**Have you ever had any type of kidney surgery?**	**Y**	**N**
List all surgeries including dates:					

Female Patients Only

Are you currently breastfeeding?	Y	N	Have you had a hysterectomy?	Y	N
Are you 55 years of age of older?	Y	N	Have you had a tubal ligation?	Y	N
Date of the first day of your last menstrual cycle?					

ATTENTION: MRI Patients and Accompanying Family Members

The MR scan room contains a very strong magnet. Some metal objects can interfere with your scan or may even be dangerous. Please, carefully read each item listed below and answer by circling Yes (Y) or No (N). If you have an ID card for anything implanted in your body, please give it to the front desk clerk prior to your MRI.

Cardiac Pacemaker or Defibrillator	Y	N	Ear Implants (Cochlear, Stapes)	Y	N
Artificial Heart Valve	Y	N	Hearing Aides	Y	N
Electrical Stimulator for Nerves or Bones	Y	N	False Teeth, Retainers, Braces	Y	N
Infusion Pump (Pain or Insulin Pump)	Y	N	Dental Magnetic Implant	Y	N
Brain or Abdominal Aneurysm Clip	Y	N	Artificial Limb or Joint	Y	N
Stents / Shunts	Y	N	Orthopedic Hardware (Plates, Pins, Screws, Rods)	Y	N
Coil, Filter, or Wire in a Blood Vessel	Y	N	Pain, Nicotine, Hormone Patches	Y	N
Are you or have you ever been a Welder?	Y	N	Penile Prosthesis	Y	N
Metal in your Eye? Was it Removed?	Y	N	Breast Tissue Expanders	Y	N
Metal Fragments, Bullets, BB's, or Pellets	Y	N	Diaphragm or IUD	Y	N
Eye Implant	Y	N	Tattoos or Tattooed Eyeliner	Y	N
Surgical Clips, Staples, Wires, Mesh, or Sutures	Y	N	Hairpins, Barrettes, or Other Metal Hair Items	Y	N
Gastric Pacemaker	Y	N	Body Piercings	Y	N

I attest that the above information is correct to the best of my knowledge. I have read and understand the contents of this form and I have asked questions, as needed, regarding the information on this form.

Patient Signature: _____ Date: _____

Accompanying Signature: _____ Date: _____

Technologist Signature: _____ Date: _____