CCHC **Coastal Carolina Health Care, P.A.**

Advanced Medicine. Trusted Care.

MRI PATIENT SCREENING FORM

Name: _____ Date: ____/____/____

Date of Birth: ____/____/____ Weight: _____

Telephone (Home): _____ Telephone (Cell): _____

---

1. Do you have any allergies (e.g., Benadryl, prednisone, adhesive tape, latex)? **Yes** **No**

   If yes, please list all allergies: _____

2. Reason for MRI and/or symptoms: _____

   _____

3. How long have you had this problem? _____

4. Was this associated with an injury? **Yes** **No**

   If yes, please describe the activity that led to the injury: _____

   _____

5. Have you had a prior surgery or procedure of any kind in this area (e.g., arthroscopy, endoscopy, steroid injection)? **Yes** **No**

   If yes, please indicate the date and type of surgery:

   Date: _____ Type of surgery: _____

   Date: _____ Type of surgery: _____

6. Have you had a prior diagnostic imaging study or examination of this area (e.g., MRI, CT, Ultrasound, X-ray)? **Yes** **No**

If yes, please list:	Body Part	Date	Facility
MRI	_____	_____	_____
CT/CAT Scan	_____	_____	_____
X-Ray	_____	_____	_____
Ultrasound	_____	_____	_____
Other: _____	_____	_____	_____

7. Do you have any other medical problems such as high blood pressure, kidney disease, diabetes, and/or cancer? **Yes** **No**

   If yes, please list:

   _____

8. Are you on dialysis? **Yes** **No**
9. Are you pregnant or breast feeding? **Yes** **No**

(Please complete information on the other side of the form)

WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure (i.e., MRI, MR angiography, functional MRI, MR spectroscopy). Do not enter the MR system room or MR environment if you have any question or concern regarding an implant, device, or object. Consult the MRI Technologist or Radiologist BEFORE entering the MR system room. **The MR system magnet is ALWAYS on.**

Please indicate if you have any of the following:					
Aneurysm clip(s)	Yes	No	Eyelid spring or wire	Yes	No
Cardiac pacemaker	Yes	No	Shunt (spinal or intraventricular)	Yes	No
Implanted cardioverter defibrillator (ICD)	Yes	No	Artificial or prosthetic limb	Yes	No
Electronic implanted or device	Yes	No	Metallic stent, filter, or coil	Yes	No
Magnetically-activated implant or device	Yes	No	Swan-Ganz or Thermodilution catheter	Yes	No
Neurostimulation system	Yes	No	Spinal cord stimulator	Yes	No
Bone growth/bone fusion stimulator	Yes	No	Vascular access port and/or catheter	Yes	No
Internal electrodes or wires	Yes	No	Radiation seeds or implants	Yes	No
Any metallic fragment or foreign body (Shrapnel, bullet, BB pellet)	Yes	No	Cochlear, otologic, or other ear implant (e.g., hearing aids)	Yes	No
Medication patch (Nicotine, Nitroglycerine)	Yes	No	Surgical staples, clips, or metallic sutures	Yes	No
Wire mesh implant	Yes	No	Heart valve prosthesis	Yes	No
Any type of prosthesis (eye, penile, etc.)	Yes	No	Bone/joint pin, screw, nail, wire, plate, etc.)	Yes	No
Insulin or other infusion pump	Yes	No	Implanted drug infusion device	Yes	No
Tissue expander (e.g., breast)	Yes	No	Joint replacement (hip, knee, etc.)	Yes	No
Denture or partial plates	Yes	No	IUD, diaphragm, or pessary	Yes	No
Tattoo or permanent makeup	Yes	No	Wig or hair implants	Yes	No

NOTE: You may be advised or required to wear earplugs or other hearing protection during the MR procedure to prevent possible problems or hazards related to acoustic noise.

I attest the above information is correct to the best of my knowledge. I have read and understand the entire contents of this form and had the opportunity to ask questions regarding this information and the MRI procedure.

Signature of person completing form: _____ Date:____/____/____

Form completed By: _____

Relationship to patient: _____

Form information reviewed by: _____ Credentials: _____

(Please complete information on the other side of the form)