

**ENVISION IMAGING OF ALLEN  
PATIENT HISTORY AND SCREENING FORM FOR MRI**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_ Sex: M F Weight: \_\_\_\_\_

DOB: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

**Clinical History:**

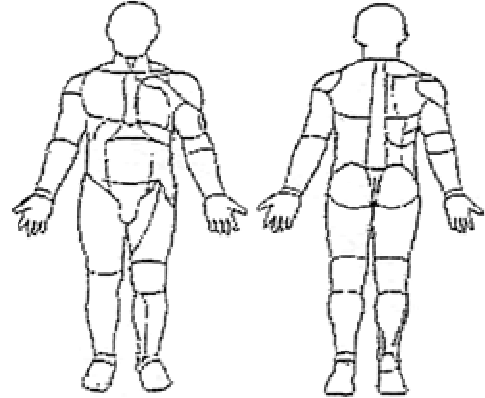
Please explain in your own words your medical problems that are the reason for your exam (MRI) today:

Have you had a previous X-ray, Sonogram, MRI or CT Scan relating to this problem? Yes No

If Yes, what type of exam was done & name of the facility that performed the exam:

**DO YOU HAVE ANY OF THE FOLLOWING ITEMS IN YOUR BODY?**

- |   |     |    |
|---|-----|----|
| Pacemaker                                 | Yes | No |
| Ear/Cochlear Implant                      | Yes | No |
| Brain/Aneurysm Clips                      | Yes | No |
| Metal in eyes or ever had any removed     | Yes | No |
| Metal fragments or shrapnel               | Yes | No |
| Implanted electrical device               | Yes | No |
| Neurostimulators                          | Yes | No |
| Stents                                    | Yes | No |
| Dentures held in with magnets             | Yes | No |
| Tattoos/Permanent Make-up                 | Yes | No |
| Body piercing(s)                          | Yes | No |
| Any other metal objects or implants _____ |     |    |



List previous Surgeries: \_\_\_\_\_

Have you ever had an injection of contrast for an MRI? Yes No

If yes, did you experience any of the following:

Hives Yes No

Shortness of breath Yes No

Please list any other medical problems: \_\_\_\_\_

List all allergies: \_\_\_\_\_

**FEMALE PATIENTS:**

Date of last menstrual period: \_\_\_\_\_

Is there any possibility of pregnancy Yes No

Are you currently breast-feeding Yes No

I have answered these questions to the best of my knowledge and understand the information that has been presented to me.

Patient/Parent/Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Technologist/Witness Signature \_\_\_\_\_ Technologist Notes : \_\_\_\_\_

**Not applicable to this exam**

\_\_\_\_\_ CC of Magnevist With a \_\_\_\_\_ @ \_\_\_\_\_ X \_\_\_\_\_ Amount  
 GA & Needle Type Time # of punctures  
 In \_\_\_\_\_ Lot \_\_\_\_\_ Expiration Date: \_\_\_\_\_  
 Site Location By: \_\_\_\_\_  
 Contrast Reaction Yes No Physician Covering Contrast \_\_\_\_\_  
 Explain \_\_\_\_\_