

# MRI SCREENING FORM



SOUTH JERSEY RADIOLOGY ASSOCIATES, P.A.

Patient MUST Complete  
DOS: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

PATIENT #: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ / AGE: \_\_\_\_ / SEX: \_\_\_\_\_

**WARNING:** Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure. **DO NOT ENTER** the MR System room or MR environment if you have any questions or concerns regarding an implant, device or object. Consult the MRI technologist or Radiologist **BEFORE** entering the MR room. The MR system magnet is **ALWAYS ON**.

**Please indicate if you have any of the following:**

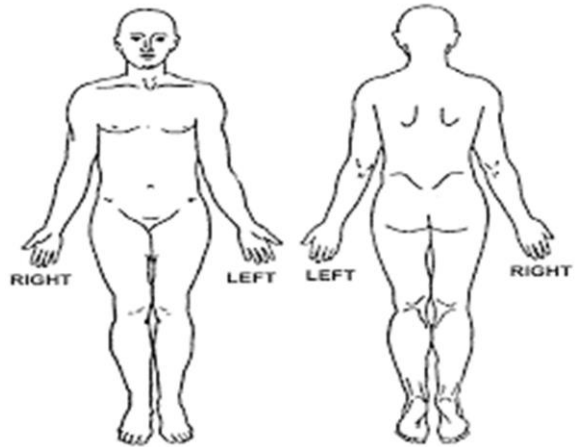
- Yes  No Aneurysm clip(s)
- Yes  No Cardiac pacemaker
- Yes  No Implanted cardioverter defibrillator (ICD)
- Yes  No Electronic implant or device
- Yes  No Magnetically-activated implant or device
- Yes  No Neurostimulator or bone stimulator
- Yes  No Brace, splint or other joint support
- Yes  No Internal electrodes or residual wires
- Yes  No Cochlear, otologic, or other ear implant
- Yes  No Insulin or other infusion pump
- Yes  No Morphine infusion pump
- Yes  No Penile prosthesis
- Yes  No Heart valve prosthesis
- Yes  No History of eye or retina surgery
- Yes  No Artificial or prosthetic limb
- Yes  No Abdominal aortic aneurysm stent graft
- Yes  No Shunt (spinal or intraventricular)
- Yes  No Radiation seeds or implants
- Yes  No Medication patch (Nicotine, Nitroglycerin)
- Yes  No Any metallic fragment or foreign body
- Yes  No Wire mesh implant
- Yes  No Breast tissue expander
- Yes  No Surgical staples, clips, or metallic sutures
- Yes  No Joint replacement (hip, knee, etc.)
- Yes  No Bone/joint pin, screw, nail, wire, plate, etc.
- Yes  No IUD
- Yes  No Dentures or partial plates
- Yes  No Body piercing jewelry
- Yes  No Hearing aid (Remove before entering)
- Yes  No Breathing problem or motion disorder
- Yes  No Claustrophobia (Afraid of confined spaces)
- Yes  No **Have you ever been injured by any metallic object (e.g. bullet, shrapnel, BB, etc.)?**
- Yes  No **Have you ever had an eye injury involving a metallic object (e.g. metallic slivers, shavings, etc.)?**

## IMPORTANT INSTRUCTIONS

Before entering the MR environment or MR system room, you must remove **ALL** metallic objects including cell phones, **ALL JEWELRY**, hearing aids, dentures, partial plates, keys, eyeglasses, hair pins, barrettes, body piercings, watches, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools. Please consult the MRI Technologist or Radiologist if you have any question or concern **BEFORE YOU ENTER THE MRI SYSTEM ROOM**. Lockers will be provided before entering the MRI Suite (Glasses, dental work, shoes can remain with you until you enter the room).

**For your safety, you will be asked to change into a gown.**

PLEASE MARK ON THE FIGURE BELOW THE LOCATION OF IMPLANTS OR METAL INSIDE OF OR ON YOUR BODY



Note: You may be advised to wear earplugs or other hearing protection during the MRI to prevent possible problems related to noise. MRI is generally a safe procedure. Qualified medical personnel will be present throughout procedure.

I attest that the above information is correct to the best of my knowledge. I have read and understand the contents of this form; had the opportunity to ask questions regarding the information on this form and regarding the MR procedure that I am about to undergo.

Signature of Person Completing Form: \_\_\_\_\_ Date: \_\_\_\_\_

If Form Completed By Someone Other than the Patient (Print name/Relationship): \_\_\_\_\_

MRI Technologist: \_\_\_\_\_

**MRI CHEST HISTORY**



SOUTH JERSEY RADIOLOGY ASSOCIATES, P.A.

Patient MUST Complete  
DOS: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

PATIENT #: \_\_\_\_\_  
PATIENT NAME: \_\_\_\_\_  
DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ / AGE: \_\_\_\_ / SEX: \_\_\_\_

**\*\*\* Please answer the following questions about your medical history to the best of your ability. Our Radiologists and staff will use the information you provide to select the most appropriate imaging techniques and to interpret the examination in order to best serve you! If you have any questions, please do not hesitate to ask.\*\*\***

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

**Why** are you having this test? \_\_\_\_\_

**Describe** your symptoms: \_\_\_\_\_

**How long** have you had these symptoms (problems)? \_\_\_\_\_

- Yes  No - Are you a current smoker?
- Yes  No - Did you smoke in the past? If you quit, how long ago? \_\_\_\_\_
- Yes  No - Have you ever had the following (please circle): COPD, emphysema, asthma, heart disease, aneurysm of the aorta, reflux or GERD (gastroesophageal reflux disease), hepatitis or liver disease, gallbladder disease or gallstones, pancreatitis, kidney stones, bowel obstruction, Crohn's disease, diverticulitis, colitis, endometriosis, fibroids, hernia.

Yes  No - Have you ever had surgery on the part of your body being imaged?

Yes  No - Have you had surgery of the lungs, heart, other?

If yes, please describe the surgery: \_\_\_\_\_

Yes  No - Do you have a personal history of lung cancer? If yes, right lung or left lung? (Please circle)

Yes  No - Do you have a personal history of other cancer? If yes, what type and when was it diagnosed?

If yes, describe how your cancer was treated (radiation/gamma knife/proton/chemo/surgery)? Please list approx. dates of treatment/procedures: \_\_\_\_\_

Please list what/when/where you've had prior studies of this body part (MRI/CT/XRays/US/Angio/Nuclear Med)?

<b>FOR WOMEN:</b> Date of last menstrual period: _____	Are you post menopausal? <input type="checkbox"/> Yes <input type="checkbox"/> No
Are you experiencing a late menstrual period? <input type="checkbox"/> Yes <input type="checkbox"/> No	Any chance that you are pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No
Are you taking any form of birth control? <input type="checkbox"/> Yes <input type="checkbox"/> No	-- If yes, list: _____

**TECHNOLOGIST USE ONLY**

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ MRI Technologist: \_\_\_\_\_ Ext: \_\_\_\_\_

I attest that the information on the form above, including technologist comments above is correct to the best of my knowledge. I have read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and regarding the MR procedure that I am about to undergo.

Signature of Person Completing Form: \_\_\_\_\_ Date: \_\_\_\_\_

If Form Completed by Someone Other than the Patient (Print name): \_\_\_\_\_

Relationship: \_\_\_\_\_