TALLAHASSEE DIAGNOSTIC IMAGING
MRI SCREENING FORM

PATIENT NAME: _____ **DATE:** _____

Some of the following items may be hazardous to your safety and some can interfere with the MRI examination. Please check the correct answer for each of the following.

☐ Yes	☐ No	Cardiac pacemaker or internal pacing wires
☐ Yes	☐ No	Implanted cardiac defibrillator or internal pacing wires
☐ Yes	☐ No	Aneurysm clip(s) or coils
☐ Yes	☐ No	Neuro-stimulator
☐ Yes	☐ No	Implanted drug infusion device (insulin or infusion pump)
☐ Yes	☐ No	Bone growth/fusion stimulator
☐ Yes	☐ No	Cochlear, otologic, or ear implant
☐ Yes	☐ No	Any type of prosthesis (eye, penile, etc.)
☐ Yes	☐ No	Heart valve prosthesis
☐ Yes	☐ No	Breast Tissue Expander(s)
☐ Yes	☐ No	Electrodes (on body, head, or brain)
☐ Yes	☐ No	Intravascular stents, filters, or coils
☐ Yes	☐ No	Shunt (spinal or intra-ventricular)
☐ Yes	☐ No	Vascular access port (Infusaport)
☐ Yes	☐ No	Any implant held in place by a magnet
☐ Yes	☐ No	Transdermal delivery system (Nitro or pain medicine patch)
☐ Yes	☐ No	Retinal Buckle for Retinal Detachment
☐ Yes	☐ No	Body piercing(s)
☐ Yes	☐ No	Any metal fragments (shrapnel, bullet, foreign body, etc.)
☐ Yes	☐ No	Aortic clip
☐ Yes	☐ No	Wire sutures or surgical staples
☐ Yes	☐ No	Harrington rods (spine) for Scoliosis Correction Surgery
☐ Yes	☐ No	Metal rods in bones
☐ Yes	☐ No	Joint replacement _____
☐ Yes	☐ No	Bone/joint pin, screw, nail, wire, plate
☐ Yes	☐ No	Hearing aid ***(Remove before MRI)***
☐ Yes	☐ No	Dentures ***(Remove before MRI)***
☐ Yes	☐ No	Claustrophobia
☐ Yes	☐ No	Anxiety

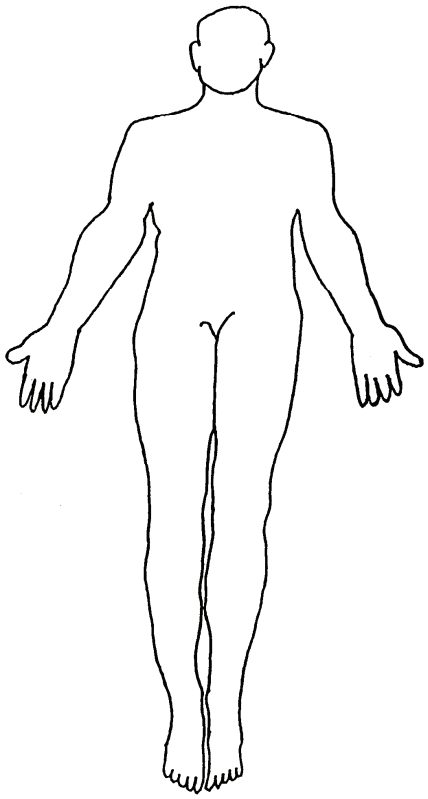
Reviewed by: **TDI Staff**

Front Desk Staff Initials: _____

Medical Assistant Initials:_____

MR Technologist Initials:_____

Please mark on the figure below, the location of any implant, or metal inside of, or on your body.



Before your MRI, please remove all metallic objects including keys, hair pins, barrettes, jewelry, watch, safety pins, paperclips, money clip, credit cards, coins, pens, belt, metal buttons, pocket knife, & clothing with metal in the material.

NOTE: YOU ARE REQUIRED TO WEAR EARPLUGS DURING THE MRI EXAMINATION.
(Please continue to the other side of this form.)

Radiology Associates of Tallahassee, P.A.
Head/Spine History Sheet

Name:_____ DOB:_____ Date:_____ Weight?_____#'s

Is there any chance you could be ***pregnant***?_____

Are you currently ***breastfeeding***?_____

Have you ever had a reaction to any **medication**?_____

If "Yes," what type of medication?_____

Have you ever had a reaction to **contrast material** ("dye") for any medical test?_____

If "Yes," what test did you have?_____

Please describe the reaction:_____

Do you have any **allergies**?_____ If "Yes," please list:_____

Are you presently taking oral antidiabetic medications for treatment of Diabetes?_____

Name of Medication:_____

Have you had **previous surgery** in the ***area you are having scanned today***?_____

If "Yes," what type and when?_____

Briefly state what symptoms you are experiencing ***relating to the procedure you are having done today***:_____

_____

_____

How long have you had these symptoms?_____

Check any of the following symptoms you have relating to your primary current complaint:

_____ Headache/Facial Pain	_____ Arm Weakness (R or L)	_____ Arm Pain (R or L)
_____ Dizziness/Balance Problems/Numbness	_____ Leg Weakness (R or L)	_____ Arm Numbness (R or L)
_____ Hearing Loss	_____ Visual Disturbances	_____ Leg Pain (R or L)
_____ Seizures	_____ Memory Loss/Confusion	_____ Leg Numbness (R or L)
_____ Neck Pain	_____ Back Pain	_____ Hip/Buttock Pain (R or L)

Are your current symptoms the result of an **auto accident**?_____

Are your current symptoms the result of another type of injury?_____

If "Yes," what type of injury?_____

Have you had a previous **CT**_____ **MRI**_____ or **Xray**_____ of the ***area you are having imaged today***?

If "Yes," where:_____ and when:_____?

Did you bring these previous studies with you today?_____

Place a check by any of the following conditions you have or have ever had:

_____ Diabetes	_____ Kidney Disease	_____ Kidney Transplant	_____ Stroke
_____ Multiple Myeloma	_____ Kidney Failure	_____ Sickle Cell Anemia	_____ Heart Failure
_____ Radiation Therapy	_____ Dialysis	_____ Tuberculosis	_____ Lupus
_____ Cancer/Tumor	_____ One Kidney	_____ Asthma	_____ High Blood Pressure

If you checked any of the above conditions, please explain:_____

_____

_____

_____

Patient Signature_____ **Date**_____ **Witness**_____

For All Patients:

1. **Do you have any drug allergies?** . . . . . ☐ No ☐ Yes

   If "Yes", please list: _____

2. **Have you ever had a reaction to contrast material (dye) for ANY medical test?** . . . . . ☐ No ☐ Yes

   If "Yes", what test did you have? _____

   Describe the reaction: _____

   _____

3. ***Please circle any of the conditions you have or have ever had:***

Kidney disease	Diabetes	Multiple myeloma	Lupus
Kidney transplant	Dialysis	Sickle cell anemia	Cancer/tumor
Kidney failure	Stroke	Heart failure	High blood pressure
One kidney	Asthma	Tuberculosis	

4. Have you ever worked with metal (grinding, fabrication, etc.) or have you ever had an injury to the eye involving a metallic object (e.g., metallic slivers, shavings or metallic foreign body)? . . . . . ☐ No ☐ Yes

5. If you answered "Yes", was the metallic object removed by a physician? . . . . . ☐ No ☐ Yes

6. If you answered "Yes", were you told by the physician that he/she removed all of the metal? . . . . . ☐ No ☐ Yes

For Female Patients:

1. Are you or could you be pregnant or experiencing a late menstrual period? . . . . . ☐ No ☐ Yes

   Date of last menstrual period: _____/_____/_____

2. Are you breastfeeding? . . . . . ☐ No ☐ Yes

_____ Date: _____/_____/_____

Signature of Person Completing Form

Form completed by: ☐ Patient ☐ Other: _____

_____ Date: _____/_____/_____

TDI Employee Reviewing MRI Safety Form