

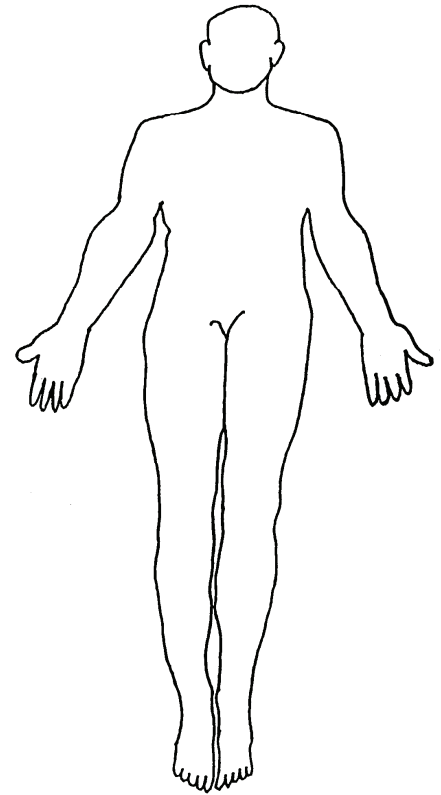
**TALLAHASSEE DIAGNOSTIC IMAGING
MRI SCREENING FORM**

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

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.

Reviewed by: TDI Staff

Front Desk Staff Initials: _____

Medical Assistant Initials: _____

MR Technologist Initials: _____

**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.

Orthopedic 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? _____

Why did your doctor send you for this test today? Briefly describe symptoms/complaints you’re having: _____

How long have you had these symptoms? _____

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

Pain Clicking Locking Abnormal Physical Exam

Swelling Popping Abnormal Xray Limited Movement

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:

Multiple Myeloma Kidney Failure Sickle Cell Anemia Smoke

Radiation Therapy One Kidney Tuberculosis Heart Failure

Kidney Disease Kidney Transplant Cancer/Tumor Lupus

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

Signature of Person Completing Form

Date: ____/____/____

Form completed by: Patient Other: _____

Date: ____/____/____

TDI Employee Reviewing MRI Safety Form