University Diagnostic Institute

Winter Park • Longwood • Orlando

TECHNOLOGIST USE ONLY

Tech Signature	Date / /

Comments: _____

MRI SCREENING FORM

Last Name	First Name	Phone ( )

☐Female ☐Male	D.O.B / /	Age	Height	Weight

Emergency Contact	Phone ( )

Reason for MRI Scan today?_____

Symptoms related to Injury? ☐ YES ☐ NO ☐ Auto Accident? ☐ Work Related? ☐ Other? Date: _____

Please list/describe symptoms you are experiencing:_____

Female patients only: Are you or do you suspect that you are pregnant? ☐ YES ☐ NO

Are you breast feeding? ☐ YES ☐ NO

When was your last menstrual period? Date:_____

PREVIOUS IMAGING STUDIES

Have you had previous MRI studies to the area being scanned today? ☐ YES ☐ NO

If YES, please list and provide dates: _____

MRI CONTRAST HISTORY

Have you ever had MRI contrast? ☐ YES ☐ NO

Did you have any kind of reaction? ☐ YES ☐ NO

If YES, please describe the type of reaction:_____

Do you have any Allergies? ☐ YES ☐ NO

If YES, please describe:

_____

Do you have Kidney Disease ☐ YES ☐ NO

If YES, are you on Dialysis? ☐ YES ☐ NO

Do you have Diabetes? ☐ YES ☐ NO

If YES, what medication(s) are you taking? _____

_____

*****If YES, to Kidney Disease or Diabetes BUN/CREATINE Labs are required with 60 days*****

Date of last blood work:_____

Facility labs were done:_____

SURGERY HISTORY

Have you had surgery to the body part being scanned today? If YES, please describe: _____ ☐ YES ☐ NO

_____

Cardiac Pacemaker	☐ YES	☐ NO
Implanted Cardiac Defibrillator (ICD)	☐ YES	☐ NO
Ear Surgery/Cochlear Implants/Hearing Aids	☐ YES	☐ NO
Eye Surgery/Implants/Spring/Wires/Retinal Tack	☐ YES	☐ NO
Neuro-Stimulator/ Bio-Stimulator/VNS	☐ YES	☐ NO
Electronic, Mechanical, Magnetic Implants	☐ YES	☐ NO
Brain Aneurysm Clips	☐ YES	☐ NO
Surgical Clips, Staples or Wires	☐ YES	☐ NO
Artificial Heart Valves	☐ YES	☐ NO
Injury to Eye Involving Metal/Metal Shavings	☐ YES	☐ NO
Gunshot Wounds/Shrapnel/BB	☐ YES	☐ NO
Heart Surgery/Heart Valve	☐ YES	☐ NO
Vascular Access Port/Catheter	☐ YES	☐ NO
Dentures or Dental Implants	☐ YES	☐ NO
Prosthesis: IUD, Diaphragm, Penile Implant	☐ YES	☐ NO
Metal Mesh Implant/Wire Sutures/Staples/Clips	☐ YES	☐ NO
Implanted Drug Infusion Pump/Insulin Pump	☐ YES	☐ NO
Titanium Plates/Pins/Screws/Rods	☐ YES	☐ NO
Shunts/Stents/Filters	☐ YES	☐ NO
Other not listed above_____		

MEDICAL HISTORY

Multiple Myeloma	☐ YES	☐ NO
Liver Disease	☐ YES	☐ NO
Blood Disease	☐ YES	☐ NO
Anemia	☐ YES	☐ NO
High Blood Pressure	☐ YES	☐ NO
Tattoos or Permanent make-up	☐ YES	☐ NO
Adrenal Gland Disease	☐ YES	☐ NO
Cancer	☐ YES	☐ NO
If YES, type and date diagnosed:		
_____		
Claustrophobic	☐ YES	☐ NO
If YES, do you need sedation?	☐ YES	☐ NO
Do you smoke	☐ YES	☐ NO
If YES, How much:_____		
How long:_____		
Ex-Smoker	☐ YES	☐ NO
Non-Smoker	☐ YES	☐ NO

PATIENT SIGNATURE

I attest that the above information is correct to the best of my knowledge. I give consent to have a contrast agent administered to me if needed for proper diagnosis of my procedure. I have read and understand the contents of this form and I have had the opportunity to ask questions regarding the information on this form.

_____ _____

PATIENT/PARENT/LEGAL REPRESENTATIVES SIGNATURE **DATE**