

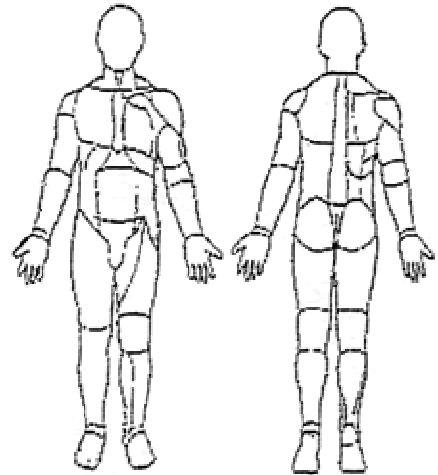
**MRI SPECIALISTS OF TULSA
PATIENT HISTORY AND SCREENING FORM FOR MRI**

Patient Name: _____ Date: _____ Sex: M F Weight _____
 DOB: _____ Referring Physician _____
 Clinical History: Please explain your medical problems that are the reason for having an MRI today: _____

 Have you had a previous X-ray, MRI or CT Scan relating to this problem? Yes No
 If Yes, what type of exam was done & name of 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 |



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 |

Other problems Explain _____

List all allergies _____

FEMALE PATIENTS

- | | | |
|---------------------------------------|-----|----|
| 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 Presented to me.

Patient/Parent/Legal Guardian Signature _____
 Date: _____ Technologist/Witness Signature _____

Not applicable to this exam				
Amount	CC of Magnevist with a	@	X	
In	Lot	GA & Needle Type	Time	# of punctures
Site Location	By:	Expiration Date:		
Contrast Reaction	Yes	No	Physician Covering Contrast	
Explain				