MRI History & Screening Form

FRi - Diagnostic Imaging
Florida Hospital Connected Care

Why are you having this MRI? _____

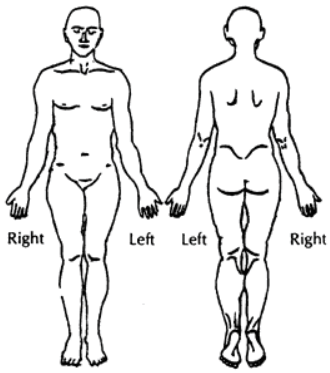
If this exam is related to an injury, how did it occur? _____

If this exam is related to pain, where is the pain located? _____

List any surgeries related to your area of pain. _____

Have you had prior imaging exams for these symptoms (MRI, CT, PET, Ultrasound, X-rays, etc.)? ☐ No ☐ Yes

If yes, please explain & list where exam was performed. _____

Please check Yes or No	Yes	No	If "Yes", explain in the below comment lines	Yes	No
The Magnet is always ON. Certain implants, devices or objects may interfere with the MRI exam and be hazardous to you.					
Cardiac pacemaker or pacer wires	☐	☐	Resolution clip device — eyelid spring or wire	☐	☐
Implanted cardiac defibrillator (ICD)	☐	☐	Any type of prosthesis (eye, penile, etc.)	☐	☐
Brain-aneurysm clip(s)	☐	☐	Artificial or prosthetic limb; external fixation system	☐	☐
Swan Ganz or thermodilution catheter	☐	☐	Female: pessary bladder device	☐	☐
Any electronic or magnetically-activated implant or device?	☐	☐	Transdermal medication patch (i.e. nicotine, nitroglycerin)	☐	☐
Any injury to eye involving metallic object or metal fragments?	☐	☐	Tattoo or permanent makeup/ Where?	☐	☐
Any metallic fragment or foreign body? Where?	☐	☐	Body piercing jewelry (please remove before exam)	☐	☐
Neurostimulation system or spinal cord stimulator	☐	☐	Hearing aids (please remove before exam)	☐	☐
Bone growth/bone fusion stimulator	☐	☐	Dentures (please remove for MRI brain exams only)	☐	☐
Any type of intravascular coil or filter/ What type?	☐	☐	Cancer or tumor history/ What type?	☐	☐
Any type of stent/ What type?	☐	☐	Gamma Knife / Date and part of body treated?	☐	☐
Programmable intraventricular shunt	☐	☐	Prior brain surgery	☐	☐
Cochlear, otologic, or other ear implant	☐	☐	Pregnancy or possibly pregnant? If "yes", how many weeks?	☐	☐
Internal electrodes or wires	☐	☐	Claustrophobia	☐	☐
Implanted drug infusion device, insulin, or other infusion pump?	☐	☐	Have you had an allergic reaction to MRI contrast?	☐	☐
Do you have an inserted SPIROL epidural catheter?	☐	☐	Obstructive sleep apnea (OSA)	☐	☐
In the last 30 days, have you had a Bravo esophageal pH test?	☐	☐	Breastfeeding / If "yes", discontinue for 24 hours please	☐	☐
Wire mesh implant or tissue expander (i.e. breast)	☐	☐	Please mark area of pain or swelling below:	☐	☐
1. Dialysis / If "yes", hemodialysis or peritoneal?	☐	☐			
2. Acute kidney disease	☐	☐			
3. Liver transplant or peri-operative liver transplantation period	☐	☐			
4. Severe liver disease or hepato-renal syndrome	☐	☐			
5. Diabetic	☐	☐			
6. Chemotherapy within 60 days	☐	☐			
7. High blood pressure <hypertension>	☐	☐			
8. IV antibiotics, other than penicillin, in last 30 days or Rifampin?	☐	☐			
9. Kidney tumor, one kidney, or kidney transplant	☐	☐			
10.Abnormal fluid in your abdomen <ascites>	☐	☐			

Comments: _____

Before entering MRI, please remove ALL metallic objects including hearing aids, keys, cell phone, hair pins, jewelry, watch, wallet, etc.

Signature of Person Completing Form _____ Print Name _____ Relationship to Patient _____ Date _____ Time _____

Technologist Authentication _____ OPID _____ Date _____ Time _____

Qualified Staff / Interpreter Signature _____ OR ☐ Phone ☐ Video (check) Print Qualified Staff / Interpreter Name _____ ID Number _____ Language Interpreted _____

Patient Label or

Patient Name _____ ☐ Female ☐ Male

DOB _____ MRN _____ Current Weight _____