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

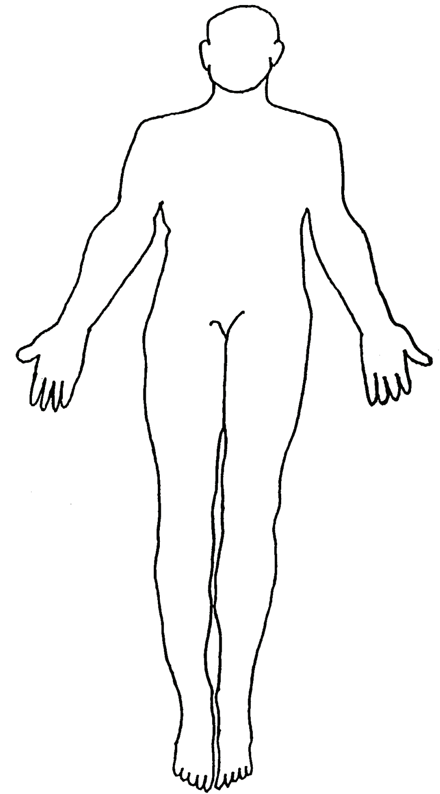
Reviewed by: **TDI Staff**

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.
Chest/Abdomen/Pelvis History Sheet

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

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

Are you currently ***breastfeeding***? ______

What **medications** are you currently taking? ______

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:

______ Pain	______ Cough	______ Coughing Up Blood/Sputum
______ Breathing Difficulty	______ Fever	______ Abnormal Xray
______ Chills/Sweats	______ Vomiting/Nausea	______ Weight Loss

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

Have you had a previous scan of the ***area you are having imaged today***?

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

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

______ Tuberculosis	______ Kidney Disease	______ Kidney Transplant	______ Lupus
______ Multiple Myeloma	______ Kidney Failure	______ Kidney Dialysis	______ Heart Failure
______ Cancer/Tumor	______ One Kidney	______ Hyperthyroidism	______ Sickle Cell Anemia
______ Diabetes	______ Asthma	______ High Blood Pressure	

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

______

______

______

Patient Signature ______ **Date** ______ **Witness** ______

<u>For All Patients</u>:

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 <u>ANY</u> 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

<u>For Female Patients</u>:

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