



**ORTHOPAEDIC
& SPORTS MEDICINE
CONSULTANTS, INC.**

MRI Patient History and Screening Form

If you have *any* questions in completing this form, call MRI at 513-424-7711, Ext 355

Pt Name _____ Date _____ Sex M F Weight _____

SS Number _____ DOB _____ Age _____ Referring Dr _____

Is your problem related to an injury? Y N Date of Injury _____ How injured? MVA Work Other

Have you had a previous MRI related to this problem? Y N

Have you taken any drugs or alcohol today to relax you? Y N If Yes, what did you take? _____

If Yes, do you have someone to drive you home? Y N

Reason you are here today? (Explain your medical problem in detail. What is the problem, where is the problem, how long have you had this problem?) _____

Do you have, or have you ever had, any of the following:

Y N Heart surgery or heart valve replacement?

Y N Brain surgery, brain aneurysm clips?

Y N Shunts, stents, intravascular coil?

Y N Eye surgery or implants?

Y N Injury to the eye by metal or metal shavings?

Y N Orthopaedic pins, screws, rods, etc?

Y N Neurostimulator or biostimulator?

Y N History of cancer or tumors?

Y N Radiation therapy or Chemo therapy?

Y N Previous back surgery (cervical or lower back)?

Y N Ear surgery, cochlear implants, hearing aids?

Y N Vascular access port?

Y N Wire sutures, staples, internal electrodes?

Y N Any electrical, mechanical or magnetic implants?

Y N Implanted drug infusion pump, insulin pump?

Y N Implanted cardiac defibrillator?

Y N Are you pregnant?

Y N Tattoos, permanent makeup, body piercing?

Y N Dentures, partials or dental implants?

Y N Any other metal in your body (shrapnel, BBs)?

Y N Hairpins, hair extensions, hair pieces, wig?

Y N Any kidney failure or disease?

List any drug allergies _____

List any surgeries _____

I have answered these questions accurately to the best of my knowledge and understand the information presented to me. I have also informed the technologist that I am not pregnant at this time.

Patient, parent or legal guardian signature

Date

DO NOT COMPLETE THIS SECTION—FOR TECHNOLOGIST ONLY

Y N Have you ever had MRI contrast injection?

Y N Did you have any reaction to the contrast?

Amount and type of Contrast

Lot number

Expiration Date

Technologist Signature