PROHEALTH Advanced Imaging UC

MRI PATIENT SCREENING QUESTIONNAIRE

Patient Name: _____ **Date:** _____

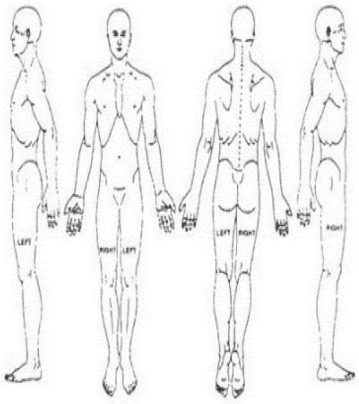
Referring Doctor: _____ **DOB:** _____ **Sex:** ___ **Weight:** __Lbs.

Reason for Procedure: Please check any of the following symptoms that you are experiencing:

☐ Chest Pain
☐ Seizures
☐ Pelvic Pain
☐ Ringing in Ears
☐ Back Pain
☐ Shoulder Pain (☐Right /☐ Left)
☐ Arm Pain (☐Right /☐ Left)
☐ Leg Numbness (☐ Right /☐ Left)
☐ Leg Weakness (☐Right / ☐Left)
☐ Other: _____

☐ Headaches
☐ Blackouts
☐ Blurred Vision
☐ Memory Loss
☐ Neck Pain

☐ Nausea
☐ Hearing Loss
☐ Dizziness
☐ Abdominal Pain
☐ Unexpected Weight Loss
☐ Arm Numbness (☐Right /☐ Left)
☐ Arm Weakness (☐Right / ☐Left)
☐ Leg Pain (☐Right / ☐Left)
☐ Hip Pain (☐Right / ☐Left)



The Nature of the Visit: Please explain your medical problem in detail. How long have you been experiencing this medical problem? _____

_____

_____

Is your problem related to an injury? ☐ Yes ☐ No *If Yes, date of the injury: _____
How injured? ☐ MVA ☐ Work ☐ Other (please explain): _____

Medical History: Do you have or have had any of the following?

☐ Cancer, Type _____ ☐ Heart Disease ☐ Kidney/Renal Disease ☐ Sickle
☐ Multiple Myeloma ☐ Hypertension ☐ Multiple Sclerosis ☐ Anemia
☐ Tumor, Lump, Mass ☐ Bleeding Tendency ☐ Heart Arrhythmia ☐ Diabetes
☐ Congenital Heart Defect ☐ Glaucoma ☐ Stroke
☐ **Previous Surgery, Date:** _____ **Type of Surgery/Level:** _____

2. Have you had any tests (MRI, CT, X-ray, etc.) performed for the symptoms you are currently experiencing or on the body part being scanned today? ☐Yes☐ No **If Yes, please list the date, modality and location of where the exam was performed:*

_____

3. Have you had any surgeries or therapies (e.g., radiation therapy, chemotherapy, etc.)?
☐ Yes ☐ No **If Yes, please list the date and type of surgery or therapy*: _____

_____

4. Are you currently taking any medications? ☐Yes☐ *No *If Yes, please list all the medications you are currently taking:* _____

_____

5. Do you have any allergies (e.g. medication, latex, food, etc.)?

_____

PROHEALTH Advanced Imaging UIC

MRI PATIENT SCREENING QUESTIONNAIRE

Please answer the following questions, which relate to metallic objects that may be present in the body:

1. Do you have a cardiac (heart) pacemaker, wires, defibrillator, or implanted heart valves? YES / NO
2. Have you ever had any brain surgery requiring aneurysm clips? YES / NO
3. Have you ever had a reaction to contract agent used for MRI, CT or X-ray? YES / NO
4. Do you have any surgical implanted material of any type in your body? YES / NO
5. Have you ever been exposed to metal fragment that could be in your eyes and/or body? YES / NO
6. Do you have a hearing aid, middle/inner ear prosthesis, stent or dentures? YES / NO
7. Do you have any type of electronic device (stimulator or pump) implanted to your body? YES / NO
8. Do you have any metal pin, joint, prosthesis or metallic object in, or attached to your body? YES / NO
9. Do you have or have you ever had tattoos, tattooed eyeliner of lip liner or body piercing? YES / NO
10. Do you wear a transdermal patch (nitroglycerin or nicotine)? YES / NO
11. Do you have a history of panic attacks or fear of enclosed places? Are you claustrophobic? YES / NO
12. Do you have a history of renal disease, seizure, asthma, emphysema? YES / NO
13. Female patients only

    Are you, or could you be, pregnant? YES / NO

    Are you breast-feeding? YES / NO

15. Are there any other items or devices you believe we should know about prior to performing the procedure? YES / NO

**If Yes, please describe:* _____

_____

WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure (i.e., MRI, MR angiography, functional MRI) DO NOT enter the MR system room or MR environment if you have any questions or concerns regarding an implant, device, or object. Consult the MRI Technologist or Radiologist BEFORE entering the MR system room. The MR system magnet is ALWAYS on.

I attest that the above information is correct to the best of my knowledge. I have read and understand the entire contents of this form and have had the opportunity to ask questions regarding the information on this form.

Patient Name: _____ **Date:** _____

Patient Signature: _____

Technologist Notes: _____

_____

_____