Advanced Imaging Centers | Ocala Health

MRI SCREENING / HISTORY SHEET

Name: _____ Date of Birth: _____

Height: _____ Weight: _____ Referring Provider: _____

Exam(s): _____

Prior surgery to this area? Yes or No _____

Symptoms or complaints: _____

_____

Injury or Trauma: _____ Date of Injury: _____

History of cancer: _____

Prior studies related to today's exam (**SAME** body part): _____

********If Contrast Is Requested********

Renal Disease / Failure / Decrease in Kidney Function?	Yes	No	
Sickle Cell Anemia?	Yes	No	
Any Blood Diseases?	Yes	No	
Ever been on Dialysis?	Yes	No	
History of Liver Transplant or Failure?	Yes	No	
Are you diabetic?	Yes	No	Type I OR Type II (Please circle)
Have you had blood work in the last 8 weeks?	Yes	No	Where? _____

Creatinine: _____ eGFR: _____ Drawn: _____

Radiologist approval signature: _____

TECH USE ONLY

GADAVIST Contrast Yes No **Lot #:** _____ **Exp. Date:** _____

ADMINISTERED Contrast Amount _____ (x10 for units given) _____ WASTED Contrast (Units) _____

Tech Name (Please circle): Althea Kelly G.

Patient Initials: _____

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Patient Name: _____

Please indicate if you have any of the following:

Cardiac Pacemaker	Yes	No	(If yes, notify the staff immediately!)
Implanted Defibrillator	Yes	No	(If yes, notify the staff immediately!)
Artificial Heart Valve	Yes	No	
Brain Aneurysm Surgery/Clips	Yes	No	
Eye Surgery (cataract lenses are ok)	Yes	No	Explain: _____
Inner Ear Surgery (Cochlear, Stapes, or Otologic Impants)	Yes	No	Explain: _____
Implanted Drug Infusion Device	Yes	No	
Shunt (Intraventrical)	Yes	No	(If yes, is it programmable?)
Penile Implant	Yes	No	
Hearing Aid	Yes	No	***Must be removed before entering scan room***
Medication Patches (Transdermal)	Yes	No	***Must be removed before entering scan room***
Joint Replacements	Yes	No	Body Part: _____ When: _____
Vascular Stents, Filters, Coils, or Grafts	Yes	No	Explain: _____
Spinal Cord/Neuro Stimulator	Yes	No	
Bladder Stimulator	Yes	No	
Body Piercings	Yes	No	Where: _____
Any metallic foreign body (i.e. bullet, pin, nail, shrapnel)	Yes	No	
Any other Implanted Electrical or Mechanical Device	Yes	No	
Have you had ANY surgeries in the last 8 weeks?	Yes	No	Type: _____
Are you claustrophobic?	Yes	No	
Any possibility you could be pregnant?	Yes	No	
Are you breastfeeding?	Yes	No	
Removable Bridgework or Dentures	Yes	No	
Do you have any breast tissue expanders?	Yes	No	
Have you had the ESSURE sterilization procedure?	Yes	No	
Are you CURRENTLY on iron infusion therapy?	Yes	No	

Have you ever had a job or hobby that involved grinding metal?	Yes	No
Have you ever had an injury to your EYES with metal particles or fragments?	Yes	No

****

I attest that the above information is correct to the best of my knowledge. I read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and regarding the MR procedure(s) that I am about to undergo.

Patient Signature: _____ **Date:** _____

Technologist Signature: _____ **Date:** _____

Radiologist Signature (if applicable): _____ **Date:** _____

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