CFW Radiology
Specialists In Diagnostic Imaging

PATIENT HISTORY AND SCREENING FORM

Patients DOB _____/_____/_____ Patients Name_____
dd mm yy Last Name First Name

The following items may interfere with your Magnetic Resonance Imaging examination, and some can be potentially hazardous.

Please indicate if you have the following: **Patient Height: _____** **Patient Weight: _____**

Cardiac pacemaker or Wires	☐ Yes ☐ No	Eyelid spring or wire	☐ Yes ☐ No
Implanted cardiac defibrillator (ICD)	☐ Yes ☐ No	Eye prosthesis	☐ Yes ☐ No
Heart valve prosthesis	☐ Yes ☐ No	Penile prosthesis	☐ Yes ☐ No
Coils, Filters, or Stents	☐ Yes ☐ No	IV access port	☐ Yes ☐ No
Brain Aneurysm clip(s)	☐ Yes ☐ No	Radiation seeds or implants	☐ Yes ☐No
Electronic/Magnetic implant or device	☐ Yes ☐ No	Intrauterine device (IUD), diaphragm, pessary	☐ Yes ☐No
Implanted drug infusion device	☐ Yes ☐ No	Artificial joint (hip, knee, shoulder, etc)	☐ Yes ☐ No
(e.g., insulin, chemo, pain meds…)		Bone/Joint pin, screw, nail, wire, plate, etc.	☐ Yes ☐ No
Bone Growth/Neurostimulator	☐ Yes ☐ No	Wire mesh implant (eg. hernia)	☐ Yes ☐ No
Shunt (renal, brain, heart, spine)	☐ Yes ☐ No	Medication patch (hormone, nicotine etc.)	☐ Yes ☐ No
Middle Ear Implants (cochlea, stapes)	☐ Yes ☐ No	Dentures or partial plates	☐ Yes ☐ No
Hearing aid	☐ Yes ☐ No	Tattoo or permanent makeup	☐ Yes ☐ No
Swan-Ganz or thermodilution catheter	☐ Yes ☐ No	Body piercing jewellery	☐ Yes ☐ No
Breast implants or tissue expanders	☐ Yes ☐ No	Have you ever had metal in your eyes?	☐ Yes ☐ No
Surgical staples, clips, wire sutures	☐ Yes ☐ No	Was the metal removed by a doctor?	☐ Yes ☐ No
Silver impregnated dressing	☐ Yes ☐ No	Are you pregnant or breast feeding?	☐ Yes ☐ No
Shrapnel or bullet	☐ Yes ☐ No	Date of Last Menstrual Period _____	

Have you ever had any surgical procedure or operation? ☐ Yes ☐ No

Type:_____ Year_____

Type:_____ Year_____

Type:_____ Year_____

You may be required to receive a contrast injection today (Gadolinium). Please read and complete the **back** of this form for information about the contrast. → **Do not sign** the **back** form until the technologist has reviewed it with you.

Have you had MRI contrast (dye) before?	☐ Yes ☐ No	Kidney disease or renal failure	☐ Yes ☐ No
Did you have a reaction?	☐ Yes ☐ No	Are you on dialysis?	☐ Yes ☐ No
Liver transplant	☐ Yes ☐ No	Please List All ALLERGIES: _____	
Sickle cell disease or Hemolytic anemia	☐ Yes ☐ No	_____	
Asthma	☐ Yes ☐ No	_____	
Diabetes	☐ Yes ☐ No		

I have answered the above questions to the best of my ability. The MRI examination has been explained to me, and I have had my questions answered to my satisfaction.

Signature of Patient or Guardian: _____ **Date** _____/_____/_____
dd mm yy

Witness: _____

*******IMPORTANT INSTRUCTIONS*******

Before entering the MRI scan room, you must remove ALL metallic objects including hearing aids, dentures, partial plates, keys, pager, cell phone, eyeglasses, hair pins, barrettes, jewellery, body piercing jewellery, watch, safety pins, money clip, credit/bank cards, coins, pens, pocket knife, nail clipper, tools, clothing with metal fasteners and/or metallic threads. The magnet is ALWAYS on!

Technologist's Notes: