CONE HEALTH®
The Network for Exceptional Care

MRI BRAIN
PATIENT HISTORY AND SCREENING

Name: ______________________ Referring Physician: ______________________

Please explain your present complaint or problem in detail: ______________________

____

How long have you had this problem? ______________________

Please check all of the following symptoms you have:

☐ Pain ☐ Confusion ☐ Difficulty walking
☐ Fainting ☐ Depression ☐ Difficulty talking
☐ Tremors ☐ Vision Problem ☐ Numbness ☐ Rt ☐ Lt
☐ Nausea ☐ Hearing Loss ☐ Weakness ☐ Rt ☐ Lt

Do you take medication for high blood pressure? ☐ No ☐ Yes

Have you had any of the following:

Head Injury? ☐ No ☐ Yes If so, when? ______________________

Did you lose consciousness? ______________________

Head surgery? ☐ No ☐ Yes If so, when and why? ______________________

Do you have a shunt? ☐ No ☐ Yes How long have you had it? ______________________

Carotid artery surgery? ☐ No ☐ Yes If so, when and where? ______________________

Do you have a personal history of cancer? ☐ No ☐ Yes

If so, do you know what kind? ______________________

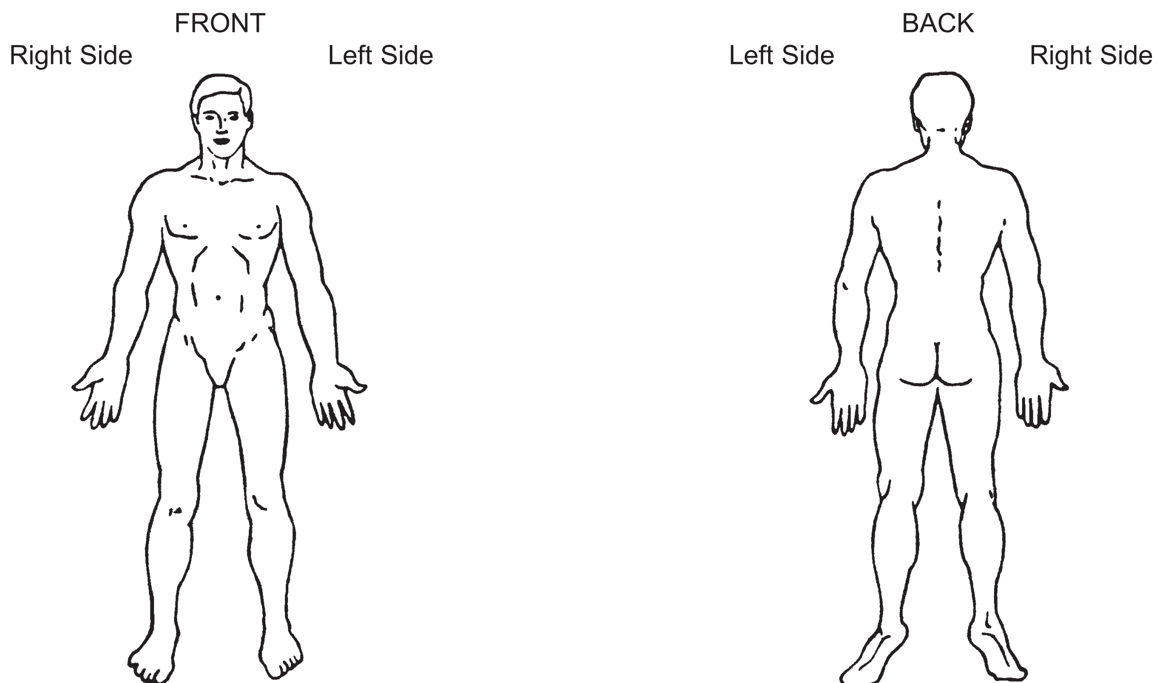
Radiation therapy to your head? ☐ No ☐ Yes When? ______________________

Are you: ☐ Right handed ☐ Left handed

Previous MRI or CT of your head? ☐ No ☐ Yes

If so, when and where? ______________________

Please circle/shade the area where you are having problems on the picture below:



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(please turn over)

PATIENT MRI SAFETY SCREENING FORM

Name:______________________________ Weight:________________

Date of Birth:____________________ Last menstrual period:_____________ N/A☐

Please check any that apply:
Possibly pregnant? ☐ Yes Claustrophobic (afraid of closed-in areas)? ☐ Yes
Have you **EVER** worked around metal grinding/filing or welding? ☐ Yes
Have you **EVER** had metal particles in your eyes? ☐ Yes

Please list any surgeries you have had : ____
____

Please list any known allergies to latex, tape or drugs that you have:
____

Please list current medications : ____
____
____

Do you have history of renal disease or dialysis? ☐ No ☐ Yes
Do you have history of High Blood Pressure? ☐ No ☐ Yes
Do you have history of diabetes? ☐ No ☐ Yes
Do you have Sickle Cell? ☐ No ☐ Yes
Do you have history of liver disease? ☐ No ☐ Yes
Do you have history of asthma? ☐ No ☐ Yes

The following items ***can*** interfere with MR imaging and ***can*** be hazardous to your safety. Please check appropriate items & notify the Technologist if you have any of the following:

______Cardiac pacemaker	______Hearing aids	______Brain clips
______Cochlear implants	______Aortic clips	______Shunts
______Carotid clips	______Joint replacements	______Neurostimulators (Tens)
______Harrington rod	______Heart valve replacements	______Bone or joint pins
______Insulin pump	______Prosthesis	______Electrodes
______Wire sutures	______Metal mesh	______Shrapnel
______Metal plates	______Dental/teeth work with magnets	
______Medication patch	______Therapeutic Magnets or screws, nails or metal rods	

______Other (please list) ____

DO NOT ENTER THE SCANNING ROOM WITH ANY OF THE FOLLOWING ITEMS:
Hearing aids, Magnetic strip cards (credit cards, bank cards), Jewelry, Hairpins/barrettes, Glasses, Watch, Wallet/Money Clip, Pocket knife, Safety pins, Pens/pencils, Phone/pager, Keys, Coins

**** Lockers will be provided to lock patient valuables ****

I have reviewed and confirmed that the above information is complete to the best of my knowledge:

Pt. Signature:_______________________________ **Date:**_____________________________

Please turn form over for additional information*****

MRI Technologist has interviewed patient: ___________________________Tech
IV angiocath started: ____ RN/Tech
IV angiocath has been D/C: ___________________________________RN/Tech