McLAREN FLINT
Flint, Michigan

MRI PATIENT HISTORY AND SCREENING FORM

Patient name: ______________________________ DOB: ____/____/____ Age: ______ Date: _____/_____/_____

MRN: ___________ Acct#:_____________ Phone: (_____) _______________ Cell: (_____) ________________

Address:____ Zip Code:_________ Ht: ______ Wt: ______ Sex: M / F

Referring Physician: _________________________________ Primary Physician:______________________________

Examination: ____

Diagnosis:____

Is this problem related to an injury? Yes / No If yes, date of injury: _____/_____/_____ WC / Auto?____________

Previous MRI related to this problem: Yes / No If yes, when & where:____

Imaging studies related to this problem: X-ray ____ CT__________

Ultrasound ____________________________________ Nuclear/Pet ___________________________________

Do you have or have you ever had any of the following? Give date and location/procedure.

☐ Yes ☐ No Claustrophobia - scale
☐ Yes ☐ No Heart surgery / Heart valve / Pacemaker____
** Patients with a pacemaker / defibrillator cannot be scanned
☐ Yes ☐ No Brain surgery / Brain aneurysm clips____
☐ Yes ☐ No Eye surgery ____
☐ Yes ☐ No Work around metal shavings / had metal removed from the eyes?___________________________
☐ Yes ☐ No Shunts / Stents / Intravascular coils ____
☐ Yes ☐ No Orthopedic pins, screws, rods, etc. ____
☐ Yes ☐ No Neurostimulator / Bone stimulator ____
☐ Yes ☐ No Previous spine surgery (low back/cervical) ____
☐ Yes ☐ No Ear surgery (cochlear /stapes implants) or hearing aids _________________________________
☐ Yes ☐ No Electrical, mechanical or magnetic implants ____
☐ Yes ☐ No Implanted drug infusion pump/insulin pump ____
☐ Yes ☐ No History of cancer _____ When __________ Area of body _______________________________
☐ Yes ☐ No Medication Patches _________________ Area of body _______________________________
☐ Yes ☐ No Gunshot wounds, shrapnel or BB's ____
☐ Yes ☐ No Any chance of pregnancy / Breast Feeding ____
☐ Yes ☐ No Tattoos / Body piercing / Permanent make-up_______________________________________
☐ Yes ☐ No IUD, Diaphragm or pessary?____
☐ Yes ☐ No Is the patient ambulatory?____

Drug Allergies: ____
History of previous surgeries: ____
____

Any kidney function problems: Yes / No Dialysis ________ Kidney Failure _________ Kidney Transplant ____

MANDATORY GFR IF THE PATIENT HAS HISTORY OF KIDNEY DX OR ONE KIDNEY.

GFR ____________________________________ **DATE DRAWN** _______ / _______ / _______

Patient's Signature: ________________________________ Date: ___________

Technologist's Signature: ________________________________ Date: ___________ Time: ___________

PT.

MR.#/P.M.

DR.

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