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 If so, how long have you had it? __________________

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

Do you have personal history of cancer? ❑ No ❑ Yes

If so, do you know what kind? ____

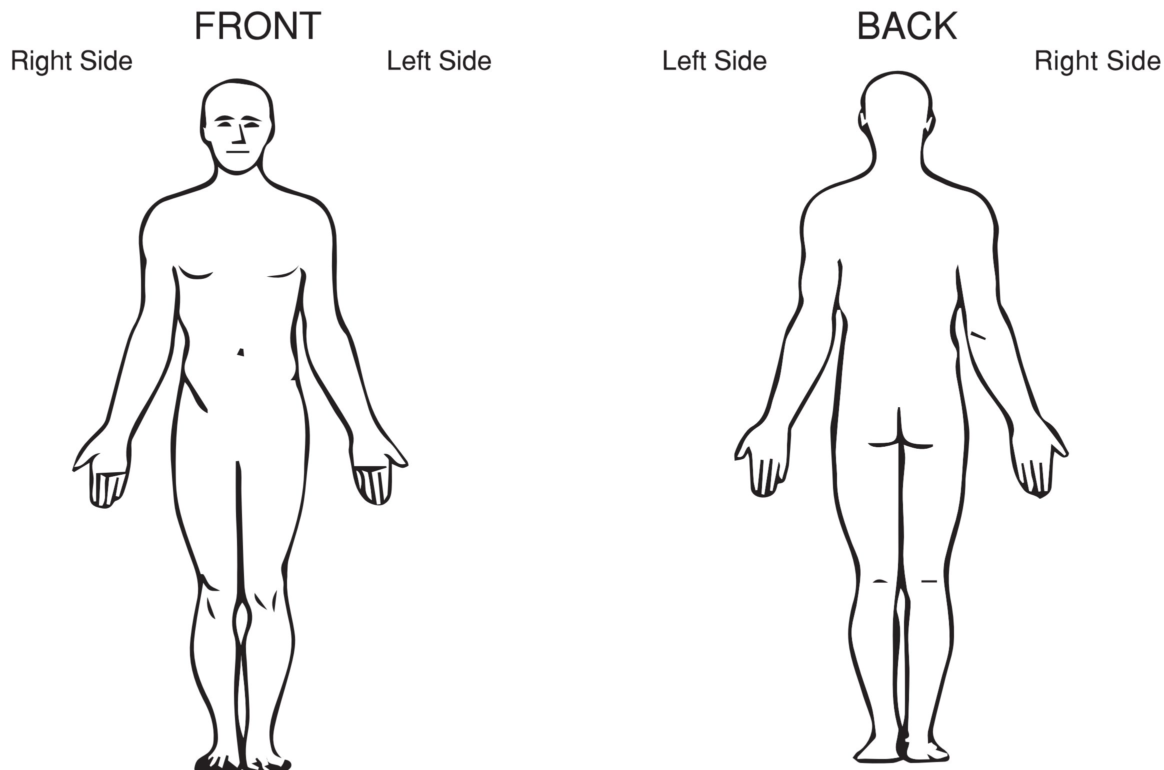
Radiation therapy to your head? ❑ No ❑ Yes

When? ____

Are you right handed? ❑ Yes Left handed? ❑ Yes

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

If so, when and where? ____



(please turn over)

NAME:________________________
DOB:________________________
WEIGHT:____________lbs.______

The following items may be harmful to you during your MRI Scan or may interfere with the MRI examination. You must provide a ''yes'' or ''no'' for every item. Please indicate if you have, or have had any of the following:

*** SIGNATURE:**	**YES**	**NO**
Any type of electronic, mechanical, or magnetic implant: eye, ear (otologic, cochlear, or other ear implant), penile, or other If yes, type: ____________________	☐	☐
Cardiac pacemaker	☐	☐
Aneurysm clip	☐	☐
Implanted cardiac defibrillator (ICD)	☐	☐
Neurostimulator / biostimulator (e.g., spinal cord or brain stimulator) If yes, type ____________________	☐	☐
Any type of internal electrodes or wires	☐	☐
Hearing aid	☐	☐
Implanted drug pump (e.g., insulin, baclofen, chemotherapy, pain medicine)	☐	☐
Halo vest	☐	☐
Spinal fixation device	☐	☐
Spinal fusion procedure	☐	☐
Any type of coil, filter, or stent If yes, where and what type?____________________	☐	☐
Any type of metal object (e.g., shrapnel, bullet, BB, metal fragment, or foreign body)	☐	☐
Bone growth / bone fusion stimulator	☐	☐
Artificial heart valve	☐	☐
Eyelid spring	☐	☐
Any type of surgical clip or staple	☐	☐
Any IV access port (e.g., Broviac, Port-a-Cath, Hickman, PICC line)	☐	☐
Medication patch (e.g., nitroglycerin, nicotine)	☐	☐
Shunt (spinal or intraventricular)	☐	☐
Prosthesis (artificial limb, joint, or eye) If yes, location:____________________	☐	☐
Tissue expander (e.g., breast)	☐	☐
Removable dentures, false teeth or partial plate	☐	☐
Diaphragm, IUD, pessary If yes, type: ____________________	☐	☐
Surgical mesh If yes, location ____________________	☐	☐
Body piercing, including dermal (under the skin) If yes, location ____________________	☐	☐
Permanent makeup (tattoos or tattooed eyeliner)	☐	☐
Radiation seeds (e.g., cancer treatment)	☐	☐
Bone / joint pins, rods, screws, nails, plates, wires, etc. If yes, location:____________________	☐	☐
Tracking device (such as an ankle bracelet provided by law enforcement)	☐	☐

TECHNOLOGIST:____________________