

EAST BAY SPORTS MEDICINE

MRI SCREENING FORM

NAME _____ AGE _____ WEIGHT _____ DOB _____

EXAM _____ DIAGNOSIS _____

ORDERING MD _____

SYMPTOMS _____

YES NO ?

PLEASE ANSWER THE FOLLOWING QUESTIONS

—	—	—	Previous MRI? At this office? _____
—	—	—	Pacemaker?
—	—	—	Brain Surgery? What kind? _____
—	—	—	Aneurysm Surgery? Head/Chest/Abdomen (circle one)
—	—	—	Chest Surgery?
—	—	—	Heart Valve?
—	—	—	Have you ever welded or worked in sheet metal?
—	—	—	Have you ever gotten metal fragments or shrapnel in your eyes?
—	—	—	Have you ever gotten metal fragments or shrapnel in your body?
—	—	—	Ear surgery? What kind? _____
—	—	—	Do you have an inner ear prosthesis?
—	—	—	Neurostimulator (TENS Unit) or electrode implant (wires)?
—	—	—	Artificial limb?
—	—	—	Insulin pump?
—	—	—	Hearing aid/Dentures? (circle)
—	—	—	Claustrophobic?
—	—	—	History of Cancer?
—	—	—	Allergies? (Including latex) _____

SURGERIES:

FEMALE PATIENTS ONLY

Pregnant? YES NO
Last Menstrual Period _____

I CONSENT TO THE MRI EXAMINATION BY EAST BAY SPORTS MEDICINE

Signature of Patient _____ Date _____