OPEN MRI
LIBERAL DIAGNOSTIC

Magnetic Resonance Procedure Screening Form

Date: _____/_____/_____ Name: _____

Social Security Number: _____-_____-_____ Date of Birth: _____/_____/_____ Gender: M/F Age: ____

Height: _____ Weight: _____ Home Phone: _____-_____-_____ Cell Phone: _____-_____-_____

Address_____City:_____ State: _____ Zip: _____

Referring Physician: _____

*** **FEMALE PATIENTS*** ** Are you pregnant at this time? Yes No Are you currently breast feeding? Yes No

***** MEDICAL HISTORY *****

Do you have **any allergies** to any foods or medications? Yes No List:_____
Are you wearing any **medication patches?** Yes No

Please list all surgeries you have had_____

What problems are you having with the area being scanned today and how long has this problem persisted?

_____

Is this due to injury?When?_____

Have you had previous x-rays, CT scans, or MRI exams on this area? Yes No When?_____

Do you have any of the following?

1. Aneurysm Clips in your brain	Y N	9. Pacemaker	Y N
2. Ear Implants	Y N	10. Defibrillator	Y N
3. Eye (Lens)/ Implants	Y N	11. Neurostimulators	Y N
4. Dentures/ Partials	Y N	12. Metal Prosthesis	Y N
5. Hearing Aid	Y N	13. IUD	Y N
6. Wigs/Hairpins	Y N	14. Metal Foreign Body	Y N
7. Insulin Pump	Y N	15. Claustrophobia	Y N
8. Breast Tissue Expander/Penile Implant	Y N	16. Pain Pump	Y N

I Certify That This Information Is Correct To The Best Of My Knowledge,

Patient Signature: _____ **Date:** _____**Time:**_____

Technologist Signature: _____ **Date:** _____**Time:**_____

Form filled out by: _____ **Date:** _____**Time:**_____