MRI PRE-EXAMINATION SCREENING FORM

Richard M. Lucas Center for Imaging
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(650) 725-9697, 723-8205

Date _____ **Magnet** ❑ 1.5T ❑ 3.0T#1 ❑ 3.0T#2 ❑ 7.0T

Name _____ Height_____ Weight_____
Last name First name M.I.

Date of Birth _____ ❑ Female ❑ Male Ethnic Origin _____

Address_____ City_____

State_____ Zip Code_____ Phone (H)(_____)_____ (W)(_____)_____

Physician's name & address_____

1. Have you ever had surgery or other invasive procedures? ❑ Yes ❑ No If yes, please list below.
   Type:_____ Date: ___/___/___
   Type:_____ Date: ___/___/___
2. Have you had any previous MR studies? ❑ Yes ❑ No If yes, please list most recent below.

Area of Body	Date	Facility Name & Location
_____	___/___/___	_____

3. Have you ever worked as a machinist, metalworker, or in any profession or hobby grinding metal? ❑ Yes ❑ No
4. Have you ever had an injury to the eye(s) by a metallic object (metallic slivers, shavings, or foreign body)? ❑ Yes ❑ No
5. Are you pregnant, experiencing a late menstrual period, or having fertility treatments? ❑ Yes ❑ No
6. Are you currently taking or have recently taken any medication? ❑ Yes ❑ No Please list:_____
7. Do you have drug allergies or have you had an allergic reaction? ❑ Yes ❑ No Please list:_____
8. Have you ever had an allergic reaction to a MR contrast media injection? ❑ Yes ❑ No
9. Do you have or previously had kidney problems? ❑ Yes ❑ No Please list:_____

Some of the following items may be HAZARDOUS to your safety and some may interfere with the MRI examination. Do you have any of the following:

❑ Yes	❑ No	Cardiac pacemaker or defibrillator	❑ Yes	❑ No	Ocular implant (eye)
❑ Yes	❑ No	Implanted cardiac pacing wires	❑ Yes	❑ No	Artificial limb or joint
❑ Yes	❑ No	Aneurysm clip or brain clip	❑ Yes	❑ No	Electrodes (body or brain)
❑ Yes	❑ No	Carotid artery vascular clamp	❑ Yes	❑ No	Shrapnel, buckshot, or bullets
❑ Yes	❑ No	Neurostimulator or DBS	❑ Yes	❑ No	Metal fragments (eye, head, ear, skin)
❑ Yes	❑ No	Spinal fusion stimulator	❑ Yes	❑ No	Tattoos: body, eyeliner, eyebrows or lips
❑ Yes	❑ No	Implanted drug infusion device	❑ Yes	❑ No	Body piercing(s) ***(Remove before scan)***
❑ Yes	❑ No	Heart valve prosthesis	❑ Yes	❑ No	Ear tubes
❑ Yes	❑ No	Aortic or vascular clips	❑ Yes	❑ No	Implant held in place by a magnet
❑ Yes	❑ No	Cochlear, otologic, or ear implant	❑ Yes	❑ No	Facelift or other cosmetic surgery
❑ Yes	❑ No	Stents, filters, or coils (vascular or other)	❑ Yes	❑ No	Metal or wire staples, sutures, mesh implants
❑ Yes	❑ No	Shunt (spine or ventricles)	❑ Yes	❑ No	Metal rods in bones; joint replacements
❑ Yes	❑ No	Vascular access port or catheters	❑ Yes	❑ No	Bone/joint pin, screw, nail, wire, plate
❑ Yes	❑ No	Swan-Ganz catheter	❑ Yes	❑ No	Wig, toupee, or hair implants, extensions
❑ Yes	❑ No	Harrington rods (spine)	❑ Yes	❑ No	Hearing aid ***(Remove before scan)***
❑ Yes	❑ No	Intrauterine Device (IUD)	❑ Yes	❑ No	Dentures ***(Remove before scan)***
❑ Yes	❑ No	Pessary or bladder ring	❑ Yes	❑ No	Asthma or breathing disorders
❑ Yes	❑ No	Transdermal drug delivery patch	❑ Yes	❑ No	Seizures or motion disorders
❑ Yes	❑ No	Prosthesis (eye/orbital, penile, etc.)	❑ Yes	❑ No	Claustrophobia

PLEASE REMOVE ALL METAL OBJECTS before the MR examination including: Cell Phone, Keys, Hair Pins, Barrettes, Jewelry, Watch, Safety Pins, Paperclips, Money Clip, Coins, Pens, Belt, Pocket Knife, Metal Buttons & Clothing with Metal. HEARING PROTECTION is required during the MRI examination.

_____ ___/___/___
Signature of Person Completing Form **Date**

Form Completed by: ❑ Patient / Volunteer ❑ Relative:_____
❑ Physician:_____ ❑ Other:_____

Form Reviewed by (please print name clearly & attach to consent form):_____