MIRAGE IMAGING

Form # 1.0

MRI Screening Form

Name_____ _____ _____ Height_____ Weight_____
(Last Name) *(First Name)* *(M.I.)*

Birth Date____/_____/_____ Phone (H) (_____) _____ (W) (_____) _____

MRI ordering physician _____

Please list any surgeries you have had:

1._____ Year: _____ 4._____ Year:_____
2._____ Year: _____ 5._____ Year:_____
3._____ Year: _____ 6._____ Year:_____

Have you taken Valium or any other sedatives today for this exam? Yes No

Is today's visit due to an injury? Yes No
If yes, Date of injury _____

Do you have a history of Cancer? Yes No
If yes, what type? _____

Is there any chance that you are pregnant? Yes No
Are you breast-feeding? Yes No

Do you have any of the following devices or conditions?
Note: Some of the following can interfere with, or prohibit you from having an MRI. The technologist will discuss this with you, if any of the following apply:

o	Cardiac Pacemaker/Defibrillator	Yes No	o	Vascular Accessed Port	Yes No
o	Eye Injury/Metal in Eyes	Yes No	o	Permanent Tattooed Makeup	Yes No
o	Leads/Heart Valve Replacement	Yes No	o	Transdermal Delivery System (Nitro)	Yes No
o	Aneurysm/Brain Clip(s)	Yes No	o	IUD (Intra Uterine Device)	Yes No
o	Neuro/Bone Stimulator	Yes No	o	Any Metal Fragments	Yes No
o	Cochlear/Inner Ear Implants	Yes No	o	Hearing Aids	Yes No
o	Insulin/Infusion Pump	Yes No	o	Dentures	Yes No
o	Prosthesis (Eye, Penile, etc.)	Yes No	o	Body Piercing(s)	Yes No
o	Intravascular Stents, Filters, or Coils	Yes No	o	Other, Please Explain_____	
o	Shunt (Spinal or Intraventricular)	Yes No			

Signature_____ Date _____

Revised 03/2012