New York Private Medical Imaging LLP

MRI SCREENING SHEET

COMPLETED BY PATIENT

PATIENT NAME: DATE:

DATE OF APPOINTMENT: / / DATE OF BIRTH: / / AGE:

REFERRING PHYSICIAN: PHONE #:

Is this your first MRI? ☐YES ☐NO How much do you weigh? ☐

Date of prior MRI: / /

Do you have any of the following:

Pacemaker?	☐YES	☐NO	Aneurysm Clips?	☐YES	☐NO
Implanted Cardiac Defibrillator?	☐YES	☐NO	Retinal Tack?	☐YES	☐NO
Cochlear Ear Implants?	☐YES	☐NO			
Implants of any kind?	☐YES	☐NO			

If YES, explain:

Could you possibly be pregnant? ☐YES ☐NO Date of last menstrual period: / /

If you answer YES to any of these questions, please call NewYork Private (212-772-7637) prior to your appointment.

Have you ever worked in a metal or machine shop? ☐YES ☐NO

Have you ever been struck in the eyes with metal shavings? ☐YES ☐NO

If YES, explain:

Foreign bodies (bullets, shrapnel, body piercing)? ☐YES ☐NO

If YES, explain:

Have you ever had:

Cranial surgery? (eg. VP shunt)	☐YES	☐NO	If YES, explain:		
Eye surgery?	☐YES	☐NO	If YES, explain:		
Neck surgery? (eg. Stent)	☐YES	☐NO	If YES, explain:		
Chest/Heart surgery? (eg. Cardiac stent)	☐YES	☐NO	If YES, explain:		
Arthroscopic surgery?	☐YES	☐NO	If YES, explain:		
Any other surgery?	☐YES	☐NO	If YES, explain:		
Hearing aid?	☐YES	☐NO	Intrauterine Device/Pessary?	☐YES	☐NO
Dentures/Partials? (including magnetic)	☐YES	☐NO	Tattoo or tattooed eye liner/brow?	☐YES	☐NO
Do you have any allergies?	☐YES	☐NO	If YES, explain:		
History of Cancer or Tumors?	☐YES	☐NO	If YES, explain:		
Have you had radiation therapy?	☐YES	☐NO	If YES, explain:		
Chemotherapy?	☐YES	☐NO	If YES, explain:		

SCREENED BY: SCREENED WITH:

Technologist comments: Technologist initials:

Additional Notes: MRI Scanner:

I verify that the answers I have provided to questions on this form are correct and understand that withholding information or inaccurate information may adversely affect the interpretation of this exam.

Patients signature: Date: / /