



Patient History & Screening Questionnaire

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: M / F Weight: \_\_\_\_\_

Clinical History: (explain why you are having this exam- what problems are you having)
\_\_\_\_\_
\_\_\_\_\_

Have you had any previous x-ray, CT or MRI scans related to this problem? Yes ( ) No ( )
If yes, where and when and were the previous scans performed? \_\_\_\_\_

Have you had any surgery? If so, what \_\_\_\_\_
Are you claustrophobic? Yes ( ) No ( )
Have you ever been a machinist, welder or metal worker? Yes ( ) No ( )
Have you ever had a piece of metal in your eye or removed from your eye? Yes ( ) No ( )
Are you diabetic? Yes ( ) No ( )
If yes, do you take glucophage, metformin/ glucovance? Yes ( ) No ( )
Do you or have you ever had cancer? If yes, what type? \_\_\_\_\_ Yes ( ) No ( )
Are you pregnant or possibly pregnant or breast feeding? Yes ( ) No ( )
Do you have any history of kidney failure? Yes ( ) No ( )
Have you ever had any X-ray contrast? Yes ( ) No ( )
Any reaction or problem with CT or MRI contrast? Yes ( ) No ( )
Any other allergies? \_\_\_\_\_ Yes ( ) No ( )

Do you have any of the following items in your body?

Pacemaker or defibrillator Yes ( ) No ( ) Body piercing Yes ( ) No ( )
Ear implant, Cochlear Implant, Hearing Aid Yes ( ) No ( ) Brain aneurysm clip Yes ( ) No ( )
Implanted catheter or tube Yes ( ) No ( ) Penile prosthesis Yes ( ) No ( )
False teeth, retainer or magnetic braces Yes ( ) No ( ) Artificial heart valve Yes ( ) No ( )
Electrical stimulator for nerves or bone Yes ( ) No ( ) Artificial limb or joint Yes ( ) No ( )
Magnetic implant anywhere Yes ( ) No ( ) Eye implant Yes ( ) No ( )
Coil, wire or filter in blood vessel Yes ( ) No ( ) Infusion pump Yes ( ) No ( )

Shunt or Stent - when was it put in \_\_\_\_\_ Yes ( ) No ( )
Surgical clips, staples, wires, mesh or stitches Yes ( ) No ( )
Ortho devices (plates, screws, pins rods, wires) Yes ( ) No ( )
Any other metal object or implants: \_\_\_\_\_ Yes ( ) No ( )

As part of your examination, the radiologist may deem it advisable to give IV contrast. This may help the physician more accurately diagnose your condition. This contrast is injected through an IV in your arm. Some reactions such as nausea, vomiting, change in blood pressure, skin rash, or other more severe reactions may occur but are uncommon with the use of this type of contrast.

I understand that the answers I have provided to questions on this form are correct to the best of my knowledge. I have read and understand the entire contents of this form and will have the opportunity to ask the technologist questions regarding this information.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_
(patient, parent or legal guardian)