RADIA®

MRI SAFETY SCREENING & MEDICAL HISTORY QUESTIONNAIRE

Because of the strong magnetic field and the potential for use of a contrast agent (dye), we must have an accurate medical and surgical history. **Please answer the questions below.**

❑ Yes ❑ No Cardiac pacemaker or defibrillator- now/before
❑ Yes ❑ No Valves, stents or filters
❑ Yes ❑ No Cochlear (ear) implant
❑ Yes ❑ No Aneurysm or aortic clip
❑ Yes ❑ No Pumps (implanted or external)
❑ Yes ❑ No Neurostimulator (spine/brain/vagus nerve)
❑ Yes ❑ No VP shunt
❑ Yes ❑ No Shrapnel/bullet fragments
❑ Yes ❑ No Metal fragment exposure to your eyes
❑ Yes ❑ No IUD
❑ Yes ❑ No Dialysis
❑ Yes ❑ No Prior reactions to MRI or CT contrast (dye)
❑ Yes ❑ No Penile implant

IF "YES" OR YOU ARE UNSURE ABOUT ANY OF THE ABOVE QUESTIONS, PLEASE TELL THE FRONT DESK STAFF IMMEDIATELY.

❑ Yes ❑ No Artificial limbs/joint replacement
❑ Yes ❑ No Harrington rods
❑ Yes ❑ No Metal/pins/screws in your body
❑ Yes ❑ No Wire sutures
❑ Yes ❑ No Surgery in the last 6 weeks
❑ Yes ❑ No Renal (kidney) disease
❑ Yes ❑ No Congestive heart failure
❑ Yes ❑ No Currently taking IV antibiotic therapy
❑ Yes ❑ No Medication patches
❑ Yes ❑ No Tattoo/cosmetic tattoo
❑ Yes ❑ No Body piercing
❑ Yes ❑ No Removable dental work
❑ Yes ❑ No Hearing aid
❑ Yes ❑ No Multiple Myeloma
❑ Yes ❑ No Diabetes
❑ Yes ❑ No Are you taking hydroxyurea?

❑ Yes ❑ No Are you on chemotherapy? If yes, list medications: _____

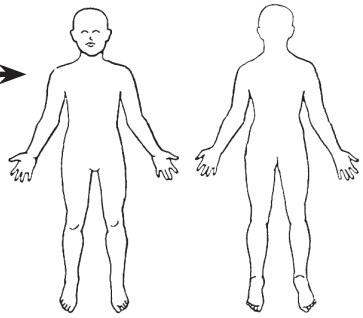
❑ Yes ❑ No Do you have any allergies, including medications? If yes, list allergies: _____

What is your current weight? _____ (lbs/kgs) What is your height? _____

Reason your doctor ordered the exam? _____

❑ Yes ❑ No Are you currently having symptoms? If yes, for how long? _____

Please mark the location of your symptoms on the diagram. →



❑ Yes ❑ No Do you have pain? If yes, does your pain **radiate** (spread out)? _____
Where: _____

❑ Yes ❑ No Have you ever had **cancer**? When: _____ Type: _____

❑ Yes ❑ No Do you **smoke**, or have a history of smoking?

❑ Yes ❑ No Have you had an **injury** to the area we are scanning today?
When: _____ Describe injury: _____

❑ Yes ❑ No Have you had any **surgeries** to the area of your body we are scanning today?
When: _____ Describe surgeries: _____

❑ Yes ❑ No Have you had past **imaging studies** of the area of your body we are scanning today?
Type of study: _____ When: _____ Where: _____
Type of study: _____ When: _____ Where: _____

❑ Yes ❑ No For female patients: Are you breastfeeding or is there any possibility that you are pregnant?

Other medical history we should know about? _____

Signature of patient: _____ Date: _____

Name of the person filling out this form, if other than the patient (please print): _____

Relationship to the patient (please print): _____

Technologist Initials: _____

Affix Pt Sticker Here

(rev 6/15)