



# MRI Patient History

MBJ MR Imaging  
2360 Mullan Rd., Suite C  
Missoula, MT 59808  
(406) 829-5567 Phone  
(406) 532-8774 Fax

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ lbs

Referring Provider: \_\_\_\_\_ Date of Exam: \_\_\_ a \_\_\_ a \_\_\_ Time of Exam: \_\_\_\_\_

Exam Type: \_\_\_\_\_  Male  Female

When did the symptoms begin? \_\_\_\_\_

Is this a result of an injury?  Yes  No If yes, please explain injury? \_\_\_\_\_

Location of pain: \_\_\_\_\_

Dislocating, locking, catching, subluxing or giving out? \_\_\_\_\_

Swelling?  Yes  No If yes, where? \_\_\_\_\_

Popping or clicking?  Yes  No If yes, where? \_\_\_\_\_

Limited Range of motion?  Yes  No If yes, which motions? \_\_\_\_\_

Have you had surgery on this body part?  Yes  No If yes, when? \_\_\_\_\_

Where? \_\_\_\_\_

Called for operative report?  Yes \_\_\_\_\_ Who performed your surgery? \_\_\_\_\_

Type? \_\_\_\_\_

Have you had any imaging of this body part?  Yes  No If yes, when? \_\_\_\_\_

Where? \_\_\_\_\_

Pushed prior imaging?  Yes \_\_\_\_\_ Type? \_\_\_\_\_

Have you had x-rays of this body part?  Yes  No If yes, when and where? \_\_\_\_\_

Pushed prior imaging?  Yes \_\_\_\_\_

History of Cancer?  Yes  No If yes, what type, when were you diagnosed, any chemo/radiation? \_\_\_\_\_

Do you have any cardiac issues?  Yes  No If yes, what? \_\_\_\_\_

Are you diabetic?  Yes  No If yes, what type and when were you diagnosed? \_\_\_\_\_

**Please mark on the diagram the location of your pain:**

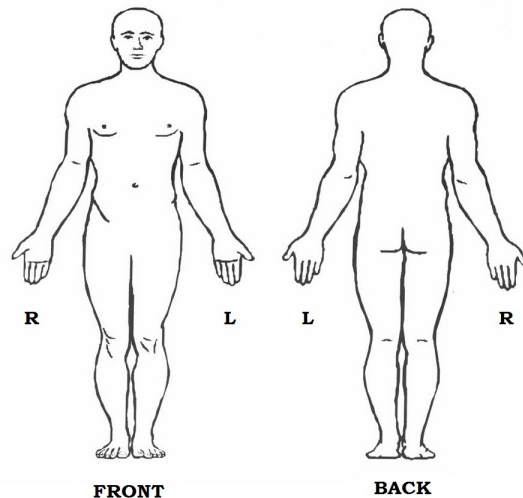
Pain / ache: XXX

Numbness: - - -

Pins and needles: 0000

Please mark with a large **X** on the diagram where the pain is the *worst* now.

**Rule Out:**





# MRI Metal Screening

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Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ ID#: \_\_\_\_\_

Date of Exam: \_\_\_\_\_ Time of Exam: \_\_\_\_\_ Ordering Provider: \_\_\_\_\_

Exam Type: \_\_\_\_\_



**WARNING:** Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure. **DO NOT ENTER** the MR system room or MR environment if you have any questions or concerns regarding an implant, device, or object. Consult the MRI Technologist or MRI Assistant BEFORE entering the MR system room. The MR system magnet is **ALWAYS** on.

**Please indicate if you have any of the following:**

- Yes  No Have you ever had a prior MRI at MBJ (1.5 T 1/2013 - current)
- Yes  No Cardiac Pacemaker
- Yes  No Pregnancy - Date of last period: \_\_\_\_\_
- Yes  No Aneurysm clip(s)
- Yes  No Claustrophobia - Pharmacy: \_\_\_\_\_ - Intramail OA  Yes
- Yes  No Have you ever been a Welder/Grinder? - X-rays Ordered  Yes
- Yes  No Any shrapnel, metallic fragment or foreign body - X-rays Ordered  Yes
- Yes  No Metallic Stent, Filter or Coil
- Yes  No Bone/joint pin, screw, nail, wire, plate, etc.
- Yes  No Surgical staples, clips, or metallic sutures
- Yes  No Joint replacement (hip, knee, etc.)
- Yes  No Shunt (spinal or intraventricular)
- Yes  No Electronic implant or device, ICD, wire mesh or magnetically-activated implant or device
- Yes  No Insulin or other infusion pump
- Yes  No Spinal cord stimulator
- Yes  No Bone growth/bone fusion stimulator
- Yes  No Neurostimulation system
- Yes  No Internal electrodes or wires
- Yes  No Implanted drug infusion device
- Yes  No Any type of prosthesis (eye, penile, heart, etc.)
- Yes  No Artificial or prosthetic limb
- Yes  No Hearing aid (Remove before entering MR Room)
- Yes  No Cochlear, otologic, or other ear implant
- Yes  No IUD, diaphragm or pessary
- Yes  No Tissue expander (e.g. Breast, Skin)
- Yes  No Radiation seeds or implants
- Yes  No Medication patch (Nicotine, Nitroglycerine)
- Yes  No Eyelid spring or wire
- Yes  No Vascular access port and/or catheter
- Yes  No Swan-Ganz or thermodilution catheter
- Yes  No Body piercing jewelry (Remove before entering MR Room)
- Yes  No Tattoo or permanent makeup
- Yes  No Dentures or partial plates

### IV CONTRAST

If the patient has answered yes to pregnancy or any known contrast allergy, the scheduler should route the order back to the referring provider for their discretion on how to proceed with the contrast exam:

- Yes No Pregnancy  Yes
- Yes No Severe allergic reaction to the MRI contrast Gadolinium
- Yes No Age >70
- Yes No History of Renal Disease
- Yes No Dialysis of any type
- Yes No Kidney transplant
- Yes No Severe hepatic disease/liver transplant/pending liver transplant
- Yes No Kidney cancer
- Yes No Prior kidney surgery
- Yes No Hypertension requiring treatment with medication
- Yes No History of Diabetes
- Yes No Recent history of chemotherapy in the past 3 months

If the patient answered "Yes" to any of the above questions, a blood draw to test for Creatinine/GFR will be ordered.

### NOTES / PENDING CLEARANCE

I attest that the above information is correct to the best of my knowledge. I read and understand the contents of this form and had the opportunity to ask questions regarding the information on the form and regarding the MR procedure that I am about to undergo. I have also been informed of other facilities to receive MRI services.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Form Information Reviewed By: \_\_\_\_\_ Date: \_\_\_\_\_

MRI Technologist  MRI Assistant