BEXAR IMAGING
A WellMed Company

Technologist's Initials

MRI HISTORY AND SCREENING

Name_____ Age_____

Date of Birth____/____/____ Sex: M / F Height_____ *Weight_____* (< 400 pounds)

Please list known drug allergies _____

Reason for today's MRI_____ What are your symptoms_____

Have you had this same exam elsewhere? If so, where? _____

Yes No Have you ever been injected with an M.R.I. dye?
Yes No Did you have an adverse or allergic reaction? **If YES**, please describe_____

DO YOU HAVE OR HAVE YOU HAD?

TECH NOTES

Yes No Pacemaker/pacemaker wires
Yes No Heart Valve/ Heart surgery/ stents/ shunts
Yes No Implanted cardiac defibrillator
Yes No Brain aneurysm clip/ Other brain surgery
Yes No Ear surgery/Cochlear Implant/Inner ear prosthesis
Yes No Vascular access port, central venous catheter
Yes No Metal slivers in eye; history of welding or metal grinding
Yes No Shrapnel/Bullet fragments/BBs/wires/Other metal foreign body
Yes No Neurostimulator/TENS/Muscular stimulator (pelvic floor, etc.)
Yes No Insulin pump/Pain pump
Yes No Diaphragm/IUD
Yes No Penile implant/Pessary/Metal mesh
Yes No IVC filter/Joint replacement/metal plates, screws, clips, orthopedic implants
Yes No Eye surgery/Ocular implants
Yes No Do you have a history of cancer? If so, what type? _____
Yes No Hearing aids/Removable dentures
Yes No Are you breastfeeding or pregnant? Date of last menstrual period:_____
Yes No Previous spine surgery?
Yes No Tattoos/Piercing with metal jewelry/Permanent makeup
Yes No History of: seizures, asthma, Diabetes, chest pain, liver problems, hepatitis, arrhythmia, sickle cell disease.
Yes No Are you currently on Dialysis?

Please describe surgeries you have had and the approximate date of each surgery:

_____ Date____/____/____

_____ Date____/____/____

_____ Date____/____/____

I have answered the above questions to the best of my knowledge.

Patient / Guardian Signature_____ Date____/____/____

If Guardian, Printed Name _____

UPDATED

Patient / Guardian Signature _____ Date____/____/____

If Guardian, Printed Name_____