TOWER IMAGING
MEDICAL · GROUP
Imaging by Specialists

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MRI SCREENING & PATIENT HISTORY

Date: _____ Patient Name: _____ Date of Birth: _____

What symptoms / problems are you currently having? _____

Have you had surgery in the area to be scanned? ☐ Yes ☐ No (if yes) When?_____

Have you had surgery related to this area / problem? ☐ Yes ☐ No (if yes) When?_____

Have you had tramma related to this area / problem? ☐ Yes ☐ No (if yes) When?_____

Please indicate if you have the following:

Cardiac Pacemaker	☐ Yes	☐ No	Diaphragm (contraceptive)	☐ Yes	☐ No
Aneurysm clip	☐ Yes	☐ No	Renal / Intraventricular shunt	☐ Yes	☐ No
Implanted drug infusion device	☐ Yes	☐ No	Breast expander	☐ Yes	☐ No
Bone growth stimulator	☐ Yes	☐ No	Artificial limb	☐ Yes	☐ No
Neurostimulator (TENS unit)	☐ Yes	☐ No	Orthopedic items: pins, rods,screws, plates	☐ Yes	☐ No
Any type of biostimulator	☐ Yes	☐ No	Electrodes / Pacing wires	☐ Yes	☐ No
Any type of removable dental items	☐ Yes	☐ No	Cochlear implant / mid-ear implant	☐ Yes	☐ No
Hearing aid	☐ Yes	☐ No	Gianturco coil (spring embolus coil)	☐ Yes	☐ No
Hemolytic or sickle cell anemia	☐ Yes	☐ No	Intravascular filter / coil stent	☐ Yes	☐ No
Renal disease / diabetes / dialysis	☐ Yes	☐ No	Any type of surgical clips or staples	☐ Yes	☐ No
Claustrophobia	☐ Yes	☐ No	Are you pregnant	☐ Yes	☐ No
Previous metal in the eye	☐ Yes	☐ No	Penile prosthesis	☐ Yes	☐ No
Orbital eye prosthesis	☐ Yes	☐ No	Asthma	☐ Yes	☐ No
Shrapnel or bullet	☐ Yes	☐ No	Tattooed eyeliner	☐ Yes	☐ No

MRI contrast history:

Have you ever had MRI contrast? ☐ Yes ☐ No

Did you ever have any kind of reaction? ☐ Yes ☐ No (if yes) explain?_____

Are you breastfeeding? ☐ Yes ☐ No

Have you ever had sever hepatic disease or liver transplant or pending liver transplant? ☐ Yes ☐ No

ATTENTION: The safety of MRI screening during pregnancy has not been established. The decision to proceed will be on an individual basis, after considering the medical necessity and alternate imaging methods. Please inform the technologist prior to your scan if you have any body or facial tattoos. Do you accept the risk that you may experience skin swelling, irritation, or possible burn to the area? If you have a problem or discomfort during the procedure, the test will be stopped.

I attest that the above information is correct to the best of my knowledge. I have read and understand the content of this form.

Patient Signature: _____ Date: _____