DODGE CITY DIAGNOSTICS

Magnetic Resonance Procedure Screening Form

Date: ___/___/___ Patient Number: _____

Name _____ Social Security Number: _____

Date of Birth: ___/___/___ Gender: M / F Age: _____ Height: _____ Weight: _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Email Address _____

Employer _____ Work Phone _____

Emergency Contact _____ Telephone _____ Relationship _____

Responsible Party for Billing _____ Address _____

Reason for MRI and/or Symptoms: _____ Referring Physician: _____

Patient History Information

1. Have you had prior surgery or an operation (e.g. arthroscopy, endoscopy, etc.) of any kind related to the body part to be examined? ☐ Yes ☐ No

   If yes, please indicate the date and type of surgery:

   Date ___/___/___ Type of surgery: _____

   Date ___/___/___ Type of surgery: _____

2. Have you had a prior diagnostic imaging study or examination (MRI, CT, Ultrasound, X-ray, etc.) related to the body part to be examined? ☐ Yes ☐ No

If yes, please list:	Body Part	Date	Facility
MRI	_____	___/___/___	_____
CT/CAT Scan	_____	___/___/___	_____
X-Ray	_____	___/___/___	_____
Ultrasound	_____	___/___/___	_____
Nuclear Medicine	_____	___/___/___	_____
Other _____	_____	___/___/___	_____

3. Have you experienced any problem related to a previous MRI examination or MR procedure? ☐ Yes ☐ No

   If yes, please describe: _____

4. Have you had an injury to the eye involving a metallic object or fragment (e.g. metallic slivers, shavings, foreign body, etc.)? ☐ Yes ☐ No

   If yes, please describe: _____

5. Have you ever been injured by a metallic object or foreign body (e.g. BB, bullet, shrapnel, etc.)? ☐ Yes ☐ No

   If yes, please describe: _____

6. Are you currently taking or have you recently taken any medication or drug? ☐ Yes ☐ No

   If yes, please list: _____

7. Are you allergic to any medication? ☐ Yes ☐ No

   If yes,please list: _____

8. Do you have a history of asthma, allergic reaction, respiratory disease, or reaction to a contrast medium or dye used for MRI, CT or X-ray exam? ☐ Yes ☐ No
9. Do you have anemia or any disease(s) that affects your blood, a history of renal (kidney) disease, or seizures? ☐ Yes ☐ No

   If yes, please describe: _____