BLUE STAR IMAGING
Boerne

MRI SCREENING FORM

Patient Name: _____

Date of Birth: _____

Male ☐ Female ☐ Weight: _____ Height: _____

ARE YOU CLAUSTROPHOBIC? ☐ YES ☐ NO

What symptoms are you experiencing? _____

Referring Physician: _____

PLEASE CHECK BELOW ALL OF THE MEDICAL CONDITIONS THAT APPLY TO YOU:

- ☐ Aneurysm Clips
- ☐ Cardiac Pacemaker
- ☐ Implanted Cardioverter Defibrillator (ICD)
- ☐ Electronic Implant or Device
- ☐ Magnetically Activated Implant or Device
- ☐ Neurostimulator
- ☐ Spinal Cord Stimulator
- ☐ Internal Electrodes or Wires
- ☐ Bone Growth Stimulator
- ☐ Cochlear, Otologic or Another Ear Implant
- ☐ Insulin Infusion Pump
- ☐ Implanted Drug Infusion Device
- ☐ ANY Type of Prosthesis (Eye, Penile, etc.)
- ☐ Heart Valve Prosthesis
- ☐ Eyelid Spring or Wire
- ☐ Orbital or Eye Implant
- ☐ Injury to Eye Involving Metallic Object or Fragment (e. g., Metallic Slivers, Shavings, Foreign Body, etc.)
- ☐ Injury by a Metallic Object or Foreign Body (e. g., BB, Bullet, Shrapnel, etc.)
- ☐ Artificial or Prosthetic Limb
- ☐ Metallic Stent, Filter, or Coil
- ☐ Shunt (Spinal or Intraventricular)
- ☐ Vascular Access Port and/or Catheter
- ☐ Radiation Seeds or Implants
- ☐ Swan-Ganz or Thermodilution Catheter
- ☐ Medication Patch (Nicotine, Nitroglycerine, Hormone, etc.)
- ☐ Wire Mesh Implant
- ☐ Tissue Expander (e. g., Breast)
- ☐ Surgical Staples, Clips, or Metallic Sutures
- ☐ Joint Replacement (Hip, Knee, etc.)
- ☐ Bone/Joint Pin, Screw, Nail, Wire, Plate, etc.
- ☐ Other _____

DO YOU HAVE A HISTORY OF CANCER? ☐ YES ☐ NO IF YES, WHERE? _____

ARE YOU ALLERGIC TO ANY MEDICATION? ☐ YES ☐ NO

IF YES, PLEASE LIST MEDICATIONS: _____

LIST PREVIOUS SURGERIES AND APPROXIMATE DATES: _____

FEMALE PATIENTS ONLY

- ☐ Is there a chance that you are pregnant?
- ☐ Are you currently pregnant?
- ☐ Have you had a hysterectomy or tubal ligation?
- ☐ Are you currently nursing?

FORM OF BIRTH CONTROL

- ☐ Abstinence
- ☐ Birth Control Pills/Patch
- ☐ Diaphragm
- ☐ Vasectomy
- ☐ Condom
- ☐ IUD
- ☐ Menopause
- ☐ None

I attest that the information I have provided for myself or family member is correct to the best of my knowledge and I hereby give consent for my procedure:

_____ Patient Signature

_____ Date

_____ Technologist Signature

_____ Date