

GREENE MEDICAL IMAGING, P.C.

X-RAY # _____

MRI SCREENING SHEET

CCF # 19 - _____

PATIENT'S NAME	WEIGHT	D.O.B.:	S.S. #
APPOINTMENT DATE/TIME	TYPE OF EXAM		PHYSICIAN

PLEASE INDICATE IF YOU HAVE ANY OF THE FOLLOWING:

This information will be needed at time of booking MRI's

	Yes	No
Cardiac Pacemakers	<input type="checkbox"/>	<input type="checkbox"/>
Brain Aneurysm Clips	<input type="checkbox"/>	<input type="checkbox"/>
Eye Implants	<input type="checkbox"/>	<input type="checkbox"/>
Ear Implants	<input type="checkbox"/>	<input type="checkbox"/>
Vascular/Surgical clips	<input type="checkbox"/>	<input type="checkbox"/>
Shunts/Stents	<input type="checkbox"/>	<input type="checkbox"/>
Pumps	<input type="checkbox"/>	<input type="checkbox"/>
Prosthesis	<input type="checkbox"/>	<input type="checkbox"/>
Wire Sutures	<input type="checkbox"/>	<input type="checkbox"/>
Any Type of Stimulator	<input type="checkbox"/>	<input type="checkbox"/>
Any Type Foreign Body, Shrapnel, Bullet, Iron	<input type="checkbox"/>	<input type="checkbox"/>
An IUD or Pessary	<input type="checkbox"/>	<input type="checkbox"/>
Dentures, or a Dental Bridge or Implant	<input type="checkbox"/>	<input type="checkbox"/>
Tattoo Eyeliner	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had metal in your eyes?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a history of cancer?	<input type="checkbox"/>	<input type="checkbox"/>
Are you pregnant or a nursing mother?	<input type="checkbox"/>	<input type="checkbox"/>
Any Previous Surgery?	<input type="checkbox"/>	<input type="checkbox"/>

What type and where: _____

Please describe your symptoms /history : _____

Any Previous Exams done pertinent to this study? (please circle) MRI CT PET Scan

Orbital X-Rays Ordered? Yes No (Neg Pos) Initial: _____

I fully understand that unforeseen results and/or complications may occur if I have not answered all questions asked of me truthfully.

PATIENT'S SIGNATURE	PARENT OR GUARDIAN	DATE
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