NYMI
NEW YORK MEDICAL IMAGING ASSOCIATES
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PATIENT'S NAME:_____ DOB: _____DATE: _____

MRI SCREENING INFORMATION SHEET

WARNING: Certain implants, devices or objects may be hazardous to you and / or interfere with the MRI procedure.
DO NOT enter the MRI room if you have any questions or concerns regarding any of the above.
Please remove ALL metallic object including hearing aids, hairpins, jewelry, credit cards, etc.

1. Do you have or have had a diagnosis of cancer? ☐ YES ☐ NO
If yes, what part of the body? _____

2. Have you had any previous X-Rays/CT Scans/ PET Scans or other scans pertaining to this exam? ☐ YES ☐ NO
If yes, please provide the following information:
Exam: _____ Where: _____ When: _____

3. Have you experienced any problems related to a previous MRI examination? ☐ YES ☐ NO
If yes, please describe: _____

4. Have you been injured by a metallic object or fragment (eg., Metal shavings, metal silvers, BB, Bullet, Shrapnel, etc.)
☐ YES ☐ NO If yes, please describe: _____
_____

5. Is this injury a result of a motor vehicle, or work related accident? ☐ YES ☐ NO

6. Any history of illness or disease? Please describe: _____
_____

For female patients: Are you pregnant? ☐ YES ☐ NO Date of last menstrual period: _____

- ☐ **Post menopausal**
- ☐ **Taking contraceptives or receiving hormonal treatment**
- ☐ **Taking any kind of fertility medication or having fertility treatments**
- ☐ **Experiencing a late menstrual period**
- ☐ **Are currently breastfeeding**

PLEASE CHECK BOX(ES) THAT APPLY TO YOU:

- ☐ **CARDIAC PACEMAKER**
- ☐ **Aneurysm clip(s)**
- ☐ **Implanted cardioverter defibrillator**
- ☐ **Electric Implant or device**
- ☐ **Magnetically-activated implant or device**
- ☐ **Neurostimulation system**
- ☐ **Spinal cord stimulator**
- ☐ **Internal electrodes or wires**
- ☐ **Insulin or other infusion pump**
- ☐ **Any type of prosthesis (eye, penile, etc.)**
- ☐ **Heart valve prosthesis**
- ☐ **Eyelid spring or wire**
- ☐ **Metallic stent, filter or coil**
- ☐ **Artificial or prosthetic limb**
- ☐ **Shunt (spinal or interventricular)**
- ☐ **Vascular access port and / or catheter**
- ☐ **Radiation seeds or implants**
- ☐ **Swan-Ganz or thermodilution catheter**
- ☐ **Medication patch (nicotine, nitro)**
- ☐ **Any metallic fragment of foreign body**
- ☐ **Wire mesh implant**
- ☐ **Tissue expander**
- ☐ **Surgical staples, clips, metallic sutures**
- ☐ **Joint replacement (hip, knee, etc.)**
- ☐ **Bone/Joint pin, screw, nail, wire, plate**
- ☐ **IUD, diaphragm, or pessary**
- ☐ **Dentures or partial plate**
- ☐ **Tattoo or permanent makeup**
- ☐ **Hearing Aid (remove before exam)**
- ☐ **Claustrophobia**
- ☐ **Other implant:** _____

PLEASE READ AND SIGN BELOW:

I, the undersigned patient, hereby authorize the doctors to perform radiological examination with administration of IV contrast and such additional procedures as are considered therapeutic on the basis of the findings during the course of the said procedure.

I hereby certify that I have read and fully understand the above.

Name: _____ Date: _____
Signature: _____Weight:_____ Employee Initial: _____