CHARTER RADIOLOGY
WHERE COMPASSION AND EXPERTISE COME TOGETHER

MRI Screening Form

Name: DOB: Age: Weight: Height: Sex:

Reason you are here today? Explain your medical problem in detail.

Patient History

Have you had previous exams related to your symptoms? ☐ Yes ☐No If yes, where / when? _____
Have you had surgery to the body part being imaged? ☐ Yes ☐No If yes, what type? _____

☐ Yes ☐ No History of Cancer or Tumors: When _____ Where _____
☐ Yes ☐ No History of Dialysis or Renal Insufficiency/Kidney Problems: _____
☐ Yes ☐ No Do you take medications for high blood pressure: _____
☐ Yes ☐ No Diabetic?
☐ Yes ☐ No Do you have any allergies?

Do you have or have you ever had any of the following?

☐ Yes	☐ No	Cardiac Pacemaker / ICD	☐ Yes	☐ No	Metal Mesh Implants / Wire Sutures
☐ Yes	☐ No	Heart Surgery / Heart Valve	☐ Yes	☐ No	Implanted Drug Infusion / Insulin
☐ Yes	☐ No	Brain Aneurysm Clips / Brain Surgery	☐ Yes	☐ No	Tattoos / Body Piercing / Patches
☐ Yes	☐ No	Neurostimulator / Biostimulator	☐ Yes	☐ No	Dentures / Partials / Dental Implants
☐ Yes	☐ No	Shunts / Stents / Filters / Coil	☐ Yes	☐ No	Gunshot Wounds / Shrapnel / BB
☐ Yes	☐ No	Orthopedic Pins / Screws / Rods / Joints / Prosthesis	☐ Yes	☐ No	Eye Surgery / Implants / Wires
☐ Yes	☐ No	Previous Back Surgery (Lumbar/Thoracic/Cervical)	☐ Yes	☐ No	Have you ever done any welding or grinding?
☐ Yes	☐ No	Ear Surgery / Cochlear Implants / Hearing Aids	☐ Yes	☐ No	Injury to the Eye Involving Metal / Metal Shavings
☐ Yes	☐ No	Electrical / Mechanical / Magnetic Implants?	☐ Yes	☐ No	Are you pregnant?
			☐ Yes	☐ No	Are you breast feeding at this time?

Acknowledgement of Notification of Privacy Practices (Please Read and Sign Below)

By signing below, you acknowledge the availability of our Notice of Privacy Practices pamphlet, which provides information about how we may use and disclose your protected health information, and is compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). We reserve the right to change the terms described, and should we do this we will post the changes in all of our offices. You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment, or health care operations. We are not required to agree with your restrictions; but if we do, we are bound by our agreement with you. Please Note: In accordance with Maryland law, we may destroy patient charts 6 years after the last documented record. In the case of a minor, records must be retained until the patient reaches the age of 18 plus 3 years, or for 5 years after the record was made, whichever is later.

Signature of Patient or Authorized Representative Date

Witness Date