UP&OPEN IMAGING
UPRIGHT MRI

MRI PROCEDURE SCREENING FORM FOR PATIENTS

Height_____ Weight_____

1. What is the primary complaint / reason for today's visit?

   _____

2. Have you had prior surgery or an operation of any kind? YES NO

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

Date ___/___/___ Type of Surgery _____

Date ___/___/___ Type of Surgery _____

Date ___/___/___ Type of Surgery _____

3. Have you had a prior diagnostic imaging study or examination?
   (ie: MRI, CT, X-Ray, Endoscopy, Colonoscopy) YES NO

If yes, please list:	Diagnostic Study	Body Part	Date	Facility
	_____	_____	_____	_____
	_____	_____	_____	_____

Have you had an injury to the eye or any other area of your body involving a metallic object or fragment?

(ie: metallic slivers, shavings, foreign body, shrapnel, bullet, etc.) YES NO

If yes, please describe: _____

4. Are you allergic to any medication? YES NO

If yes, please list: _____

5. 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 examination? YES NO
6. Do you have anemia or any disease(s) that affects your blood, a history of renal (kidney) disease, seizures, a history of diabetes, or hypertension / high blood pressure? YES NO

If yes, please describe: _____

_____

FOR FEMALE PATIENTS:

7. Date of last menstrual period: ___/___/___ Post Menopausal? YES NO
8. Are you pregnant or experiencing a late menstrual period? YES NO