OAL MRI North Pointe
170 North Pointe Blvd
Lancaster, PA 17601
717.735.6641

OAL MRI Lebanon
1701 Cornwall Rd Suite 200
Lebanon, PA 17042
717.675.1307

PATIENT SCREENING FORM

DEMOGRAPHIC INFORMATION

Patient Name:_____ Study Date:_____

DOB:_____ Height: _____ Weight:_____ MRN: _____

Prior Surgeries of ANY kind (Type & Date) - Please list: _____

_____

List Known Allergies:_____

PATIENT SCREENING QUESTIONNAIRE

Procedure/Surgical History	Please put a √ in correct box and answer each question in its entirety		
Pacemaker	☐ YES	☐ NO	
Defibrillator/Implanted Devices	☐ YES	☐ NO	
Neurostimulator	☐ YES	☐ NO	
Loop Recorder	☐ YES	☐ NO	
Heart Valve/Stent/Filter/Coil	☐ YES	☐ NO	Location/Type/Date:_____
Heart or Brain Surgery	☐ YES	☐ NO	Location/Type/Date:_____
Eye or Ear Surgery	☐ YES	☐ NO	Location/Type/Date:_____
Aneurysm Repair	☐ YES	☐ NO	Brain ☐ Abdomen ☐
VP Shunt Device	☐ YES	☐ NO	Location/Type/Date:_____
Back or Neck Surgery	☐ YES	☐ NO	
Any history of metal in your eyes	☐ YES	☐ NO	
Bullets/BBs/Shrapnel inside body	☐ YES	☐ NO	Where is it located:_____

MRI Clearances	Please put a √ in correct box and answer each question in its entirety		
Hearing Aid/Cochlear Implant	☐ YES	☐ NO	
Dentures/Partial Plate	☐ YES	☐ NO	
Tattoos/Permanent Eyeliner	☐ YES	☐ NO	
Latex Allergy	☐ YES	☐ NO	
Implant (clip/pin/plate/screw/rod)	☐ YES	☐ NO	Location/Type/Date:_____
Insulin Pump/Glucose Monitor	☐ YES	☐ NO	Location/Type/Date:_____
Extremity Prosthesis or brace	☐ YES	☐ NO	Location/Type/Date:_____
Medication Patches	☐ YES	☐ NO	Location/Type/Date:_____
Body Piercing Site(s)	☐ YES	☐ NO	Location/Type/Date:_____
Penile Implant	☐ YES	☐ NO	Location/Type/Date:_____
Chance of Pregnancy	☐ YES	☐ NO	LMP:_____ IUD Brand:_____

Contrast Contraindications	Do you have any of the following?		
High Blood Pressure	☐ YES	☐ NO	
Kidney Disease/Renal Failure	☐ YES	☐ NO	If yes, are you on dialysis:_____
Diabetes	☐ YES	☐ NO	
Chronic Liver Disease	☐ YES	☐ NO	
Organ Transplant	☐ YES	☐ NO	
Cancer	☐ YES	☐ NO	Type:_____ ☐ Chemo ☐ Radiation
Have you ever had an allergy to MRI contrast or reaction to MRI contrast in the past?			☐ YES ☐ NO
Are you actively breastfeeding?	☐ YES	☐ NO	

Patient Signature:_____ Date:_____