OAL MRI NORTH POINTE
North Pointe Business Park
170 North Pointe Blvd.
Lancaster, PA 17601
717.735.6641

OAL MRI LEBANON
1701 Cornwall Road
Suite 200
Lebanon, PA 17042
717.675.1307

PATIENT SCREENING FORM

DEMOGRAPHIC INFORMATION

Patient Name: _____ Study Date: _____

Date of Birth: _____ Height: _____ Weight: _____ MRN: _____

Prior surgeries of **ANY** kind **(Type & Date)**: **Please List Below ***** Any surgeries in the last 8 weeks ☐ NO ☐ YES

List Known Allergies: _____

PATIENT SCREENING QUESTIONNAIRE

Medical History	**Please put a √ in correct box and answer each question in its entirety**				
High Blood Pressure	☐ YES	☐ NO	Cancer (Type) _____	☐ YES	☐ NO
Kidney Disease/Renal Failure	☐ YES	☐ NO	☐ Chemotherapy ☐ Radiation Therapy		
Diabetes	☐ YES	☐ NO	Chronic Liver Disease	☐ YES	☐ NO
Frequent Bronchitis/Asthma	☐ YES	☐ NO	Organ Transplant	☐ YES	☐ NO
Procedure/Surgical History	**Please put a √ in correct box and answer each question in its entirety**				
Pacemaker/Defibrillator/Wires	☐ YES	☐ NO	Back/Neck Surgery	☐ YES	☐ NO
Heart Valve/Filters/Coils/Stents	☐ YES	☐ NO	Aneurysm repair □ brain □ abdominal	☐ YES	☐ NO
Neurostimulator	☐ YES	☐ NO	Shunts	☐ YES	☐ NO
Metal Fragments in Eye	☐ YES	☐ NO	Metal Fragments-BBs, Bullets, Shrapnel	☐ YES	☐ NO
Implant Device (clip/pin/plate/screw/rod)	☐ YES	☐ NO	Location/Type/Date of Implant _____		
Heart/Brain Surgery (incl. eyes & ears)	☐ YES	☐ NO	Location/Type/Date of Implant _____		
MRI Clearances	**Please put a √ in correct box and answer each question in its entirety**				
Hearing Aid	☐ YES	☐ NO	Tattoos/Permanent Eyeliner	☐ YES	☐ NO
Dentures/Partial Plate	☐ YES	☐ NO	Latex Allergy	☐ YES	☐ NO
Pain Pump/Insulin Pump/Wound Vac	☐ YES	☐ NO	Type _____		
Extremity Prosthesis or brace	☐ YES	☐ NO	Location _____		
Medication Patches	☐ YES	☐ NO	Location/Type _____		
Body Piercing Site(s)	☐ YES	☐ NO	Location _____		
Skin Staples-Site	☐ YES	☐ NO	Location _____		
Male patients: Penile implant	☐ YES	☐ NO	Brand _____		
Female patients: Chance of pregnancy	☐ YES	☐ NO	LMP _____		
Intrauterine Device (IUD)	☐ YES	☐ NO	Brand _____		

Contrast Contraindications	**Please put a √ in correct box and answer each question in its entirety**	
Are you actively breastfeeding?	☐ YES	☐ NO
Have you had any lab work in the last 30 days? Where _____	☐ YES	☐ NO
Have you ever been told that you have an allergy to MRI contrast?	☐ YES	☐ NO
Have you ever had a reaction to contrast with an MRI study?	☐ YES	☐ NO
Have you ever had an allergy that caused an anaphylactic response?	☐ YES	☐ NO
Have you ever been diagnosed with Advanced Renal Dysfunction (GFR <60cc/min)?	☐ YES	☐ NO
Are you currently undergoing dialysis?	☐ YES	☐ NO
Have you ever been diagnosed with Nephrogenic Systemic Fibrosis (NSF)?	☐ YES	☐ NO
Have you received IV iron injections/ Feraheme in the last 3 months?	☐ YES	☐ NO

Patient Signature: _____ Date: _____