MAGNETIC RESONANCE (MR) CONTRAST SCREENING FORM

Date _____/_____/_____

Name _____ Age _____ Weight _____
Last name First name Middle Initial

Date of Birth _____/_____/_____ Male ☐ Female ☐
month day year

1. Have you experienced any problem related to a previous MRI examination or MR procedure? ☐ No ☐ Yes
If yes, please describe: _____

2. Are you currently taking or have you recently taken any medication or drug? ☐ No ☐ Yes
If yes, please list:_____

3. Are you allergic to any medication? ☐ No ☐ Yes
If yes, please list:_____

4. Do you have a history of asthma, allergic reaction, respiratory disease, or reaction to a contrast medium or dye used for an MRI, CT, or X-ray examination? ☐ No ☐ Yes

5. Do you have anemia or any disease(s) that affects your blood, a history of renal (kidney) disease, renal (kidney) failure, renal (kidney) transplant, high blood pressure (hypertension), liver (hepatic) disease, diabetes or seizures? ☐ No ☐ Yes
If yes, please describe: _____

For female patients:
6. Date of last menstrual period:_____/_____/_____ Post menopausal? ☐ No ☐ Yes

7. Are you pregnant or experiencing a late menstrual period? ☐ No ☐ Yes

8. Are you taking oral contraceptives or receiving hormonal treatment? ☐ No ☐ Yes

9. Are you taking any type of fertility medication or having fertility treatments? ☐ No ☐ Yes
If yes, please describe: _____

10. Are you currently breastfeeding? ☐ No ☐ Yes

I attest that the above information is correct to the best of my knowledge. I read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and regarding the MR procedure that I am about to undergo.

Signature of Person Completing Form: _____ Date _____/_____/_____
Signature

Form Completed By:
☐ Patient ☐ Relative ☐ Nurse _____ _____
Print Name Relationship to patient