VANGUARD DIAGNOSTIC

PLEASE COMPLETE ALL FIELDS TO THE BEST OF YOUR ABILITY. YOUR RESPONSES WILL DETERMINE MEDICAL CLEARANCE FOR THE IMAGING PROCEDURE. IF YOU HAVE ANY QUESTIONS REGARDING THIS MATERIAL, PLEASE ASK STAFF FOR ASSISTANCE WHEN YOU BRING THIS FORM TO HAVE THE PROCEDURE.

PATIENT NAME: _____ TODAY'S DATE: _____ _____

DATE OF BIRTH: _____ AGE: _____ PATIENT GENDER: ☐ MALE ☐ FEMALE

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1. 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: _____
   DATE: _____ TYPE: _____
   DATE: _____ TYPE: _____
   DATE: _____ TYPE: _____

2. HAVE YOU HAD A PRIOR DIAGNOSTIC IMAGING STUDY OR EXAMINATION? ☐ YES ☐ NO
   IF YES, PLEASE LIST TYPE OF SCAN, DATE, & FACILITY:
   ☐ MRI/MRA BODY PART: _____ DATE: _____ FACILITY: _____
   ☐ CT/CAT SCAN BODY PART: _____ DATE: _____ FACILITY: _____
   ☐ X-RAY BODY PART: _____ DATE: _____ FACILITY: _____
   ☐ ULTRASOUND BODY PART: _____ DATE: _____ FACILITY: _____
   ☐ NUCLEAR MEDICINE BODY PART: _____ DATE: _____ FACILITY: _____
   ☐ OTHER _____ BODY PART: _____ DATE: _____ FACILITY: _____

3. HAVE YOU EXPERIENCED ANY PROBLEM RELATED TO A PREVIOUS MRI OR MR PROCEDURE? ☐ YES ☐ NO
   IF YES, PLEASE DESCRIBE: _____

4. ARE YOU ALLERGIC TO ANY MEDICATION(S)? ☐ YES ☐ NO
   IF YES, PLEASE DESCRIBE: _____

5. 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? ☐ YES ☐ NO

6. DO YOU HAVE ANEMIA (SICKLE CELL) OR ANY DISEASE(S) THAT AFFECTS YOUR BLOOD? ☐ YES ☐ NO
   IF YES, PLEASE DESCRIBE: _____

7. ARE YOU A DIABETIC OR DO YOU HAVE KIDNEY PROBLEMS? ☐ YES ☐ NO
   IF YES, PLEASE DESCRIBE: _____

8. DO YOU HAVE COLLAGEN VASCULAR DISEASE (LUPUS), MYELOMA, OR LIVER DISEASE? ☐ YES ☐ NO
   IF YES, PLEASE DESCRIBE: _____

9. ARE YOU PREGNANT? ☐ YES ☐ NO

Please bring this form with you on the date of your exam.

WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure *(i.e. MRI, MRA, functional MRI, MR spectroscopy)*. DO NOT ENTER the MR room or MR environment if you have any question or concern regarding an implant, device, or object. The MR magnet is ALWAYS on. Please consult with the MRI Technologist/Radiologist BEFORE entering the MR room.

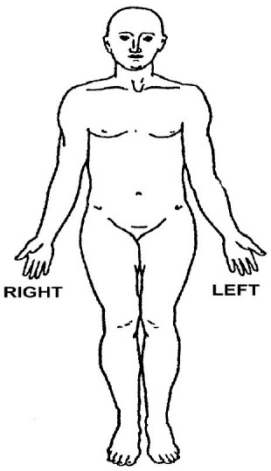
Patient Name: _____ Height: _____ Weight: _____

Please indicate if you have any of the following, if yes, please specify:

❑ Yes ❑ No **Aneurysm clip(s)**
❑ Yes ❑ No **Cardiac pacemaker**
❑ Yes ❑ No **Implanted cardioverter defribilator *(ICD)***
❑ Yes ❑ No **Any medical implant or device** *Please specify:*_____
❑ Yes ❑ No **Neurostimulation system**
❑ Yes ❑ No **Spinal cord stimulator**
❑ Yes ❑ No **Internal electrodes or wires** *Please specify:*_____
❑ Yes ❑ No **Bone growth/bone stimulator**

❑ Yes ❑ No Cochlear, otologic, outer ear implant *Please specify:*_____
❑ Yes ❑ No Eyelid spring or wire
❑ Yes ❑ No Any type of prosthesis *Please specify:*_____
❑ Yes ❑ No Artificial or prosthetic limb
❑ Yes ❑ No Metallic stent, filter, or coil *Please specify:*_____
❑ Yes ❑ No Shunt *(Spinal or ventricular)*
❑ Yes ❑ No Vascular access port and/or catheter
❑ Yes ❑ No Radiation seeds or implants
❑ Yes ❑ No Medication patch *(Remove before entering MR room)*
❑ Yes ❑ No Any metallic fragment or foreign body *Please specify:*_____
❑ Yes ❑ No Injury to eye from metallic fragment
❑ Yes ❑ No Wire mesh implant
❑ Yes ❑ No Tissue expander
❑ Yes ❑ No Surgical staples, clips, or metallic sutures *Please specify:*_____
❑ Yes ❑ No Joint replacement
❑ Yes ❑ No Bone/joint pin, screw, nail, wire, plate, etc.
❑ Yes ❑ No IUD, diaphragm, or pessary *Please specify:*_____
❑ Yes ❑ No Dentures or partial plates
❑ Yes ❑ No Tattoo or permanent makeup
❑ Yes ❑ No Any programmable implant or device *Please specify:*_____
❑ Yes ❑ No Any other implant *Please specify:*_____
❑ Yes ❑ No Body piercing jewelry *(Remove before entering MR system room)*
❑ Yes ❑ No Hearing aid *(Remove before entering MR system room)*
❑ Yes ❑ No Breathing problem or motion disorder
❑ Yes ❑ No Claustrophobia *(Is medication needed?* ❑ Yes ❑ No*)*
If yes, please request a prescription from your physician.

Please mark on the figure the location of any implant or metal on or inside of your body.



If you answered yes to any of the questions to your left, please list the type of implant, stent, or device you have, if you have a medical information card, and the date and facility where it was placed.

Are you pregnant?
❑ Yes ❑ No ❑ N/A

Would you like music during the scan?
❑ Yes ❑ No

Additional notes:

IMPORTANT INSTRUCTIONS: Before entering the MR room or MR environment, you must remove ALL metallic objects including hearing aids, dentures, partial plates, keys, pager, cell phone, eyeglasses, hair pins, barrettes, jewelry, body piercing jewelry, watch, belt, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clippers, tools, clothing with metal fasteners, and clothing with metallic threads.

NOTE: You may be advised or required to wear earplugs or other hearing protection during the MR procedure to prevent possible problems or hazards related to acoustic noise.

❑ **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 about the information on this form regarding the MR procedure that I am about to undergo.**

❑ **I attest that there have been no changes to the above indications since I last completed this MR Screening Questionnaire.**

Signature of patient: _____ Date: _____

Signature of person completing form: _____ Date: _____

Form completed by: ❑ Patient ❑ Texas Neurology Staff ❑ Other *(Please specify)*: _____

Signature of person reviewing form: _____ Date: _____