St. Anthony Hospital
Centura Health

Patient Label

Magnetic Resonance (MR) Procedure Screening Form For Patients
#SAH0059RD rev. 07/11

QUESTIONNAIRE

Magnetic Resonance (MR) Procedure Screening Form For Patients

Date: _____/_____/_____ Age: _____ Height: _____ Weight: _____

☐ Male ☐ Female Body Part to be Examined: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone (home) (_____) _____-_____ Telephone (work) (_____) _____-_____

Reason for MRI and/or Symptoms: _____

Referring Physician: _____ Telephone (_____) _____- _____

1. Have you had prior surgery or an operation (e.g., arthroscopy, endoscopy, etc.) of any kind? ☐ No ☐ Yes
   If yes, please indicate the date and type of surgery:
   Date: _____/_____/_____ Type of surgery: _____
   Date: _____/_____/_____ Type of surgery: _____
2. Have you had a prior diagnostic imaging study or examination (MRI, CT, Ultrasound, X-ray, etc.)? ☐ No ☐ Yes
3. Have you experienced any problem related to a previous MRI examination or MR procedure? ☐ No ☐ Yes
   If yes, please describe: _____
4. Have you had an injury to the eye involving a metallic object or fragment (e.g., metallic slivers, shavings, foreign body, etc.)? ☐ No ☐ Yes
   If yes, please describe: _____
5. Have you ever been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel, etc.)? ☐ No ☐ Yes
   If yes, please describe: _____
6. Are you currently taking or have you recently taken any medication or drug? ☐ No ☐ Yes
   If yes, please describe: _____
7. Are you allergic to any medication? ☐ No ☐ Yes
   If yes, please list: _____
8. 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
9. 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, a history of diabetes, or seizures? ☐ No ☐ Yes
   If yes, please describe: _____

For female patients:

10. Date of last menstrual period: _____/_____/_____ Post menopausal? ☐ No ☐ Yes
11. Are you pregnant or experiencing a late menstrual period? ☐ No ☐ Yes
12. Are you taking oral contraceptives or receiving hormonal treatment? ☐ No ☐ Yes
13. Are you taking any type of fertility medication or having fertility treatments? ☐ No ☐ Yes
    If yes, please describe: _____
14. Are you currently breastfeeding? ☐ No ☐ Yes

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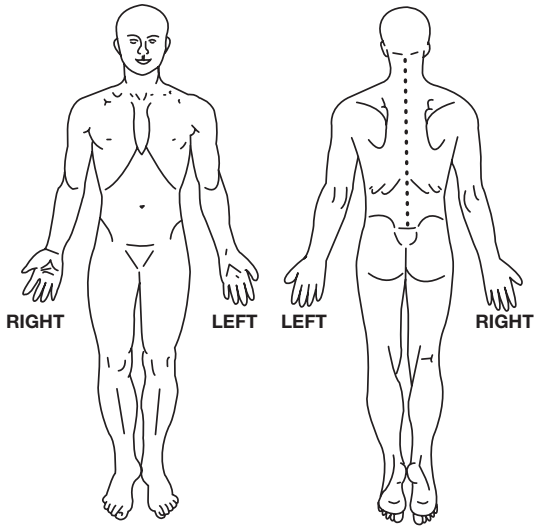
WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure (i.e., MRI, MR angiography, functional MRI, MR spectroscopy). Do not enter the MR system room or MR environment if you have any question or concern regarding an implant, device, or object. Consult the MRI Technologist or Radiologist BEFORE entering the MR system room. The MR system magnet is ALWAYS on.

Please indicate if you have any of the following:

- ☐ Yes ☐ No Aneurysm clip(s)
- ☐ Yes ☐ No Cardiac pacemaker
- ☐ Yes ☐ No Implanted cardioverter defibrillator (ICD)
- ☐ Yes ☐ No Electronic implant or device
- ☐ Yes ☐ No Magnetically-activated implant or device
- ☐ Yes ☐ No Neurostimulation system
- ☐ Yes ☐ No Spinal cord stimulator
- ☐ Yes ☐ No Internal electrodes or wires
- ☐ Yes ☐ No Bone growth/bone fusion stimulator
- ☐ Yes ☐ No Cochlear, otologic, or other ear implant
- ☐ Yes ☐ No Insulin or other infusion pump
- ☐ Yes ☐ No Implanted drug infusion device
- ☐ Yes ☐ No Any type of prosthesis (eye, penile, etc.)
- ☐ Yes ☐ No Heart valve prosthesis
- ☐ Yes ☐ No Eyelid spring or wire
- ☐ Yes ☐ No Artificial or prosthetic limb
- ☐ Yes ☐ No Metallic stent, filter, or coil
- ☐ Yes ☐ No Shunt (spinal or intraventricular)
- ☐ Yes ☐ No Vascular access port and/or catheter
- ☐ Yes ☐ No Radiation seeds or implants
- ☐ Yes ☐ No Swan-Ganz or thermodilution catheter
- ☐ Yes ☐ No Medication patch (Nicotine, Nitroglycerine)
- ☐ Yes ☐ No Any metallic fragment or foreign body
- ☐ Yes ☐ No Wire mesh implant
- ☐ Yes ☐ No Tissue expander (e.g., breast)
- ☐ Yes ☐ No Surgical staples, clips, or metallic sutures
- ☐ Yes ☐ No Joint replacement (hip, knee, etc.)
- ☐ Yes ☐ No Bone/joint pin, screw, nail, wire, plate, etc.
- ☐ Yes ☐ No IUD, diaphragm, or pessary
- ☐ Yes ☐ No Dentures or partial plates
- ☐ Yes ☐ No Tattoo or permanent makeup
- ☐ Yes ☐ No Body piercing jewelry
- ☐ Yes ☐ No Hearing aid
  (Remove before entering MR system room)
- ☐ Yes ☐ No Other implant: _____
- ☐ Yes ☐ No Breathing problem or motion disorder
- ☐ Yes ☐ No Claustrophobia

Please mark on the figure(s) below the location of any implant or metal inside of or on your body.



IMPORTANT INSTRUCTIONS.

Before entering the MR environment or MR system room, you must remove all metallic objects including hearing aids, dentures, partial plates, keys, beeper, cell phone, eyeglasses, hair pins, barrettes, jewelry, body piercing jewelry, watch, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools, clothing with metal fasteners, & clothing with metallic threads.

Please consult the MRI Technologist or Radiologist if you have any question or concern BEFORE you enter the MR system room.

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 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

Form Information Reviewed By: _____ _____
Print name Signature

☐ MRI Technologist ☐ Nurse ☐ Radiologist ☐ Other: _____

St. Anthony Breast Center

Centura Health

PATIENT'S NAME: _____

Is there any possibility that you are pregnant? □ Yes □ No **How did you hear about us?** _____

Best phone number to contact you: _____

Can we leave a voice mail message regarding **normal results**? □ Yes □ No

If you are not available, can we leave a message with whoever answers the phone? □ Yes □ No

PREVIOUS MAMMOGRAM:

□ Yes □ No Location: _____Date: _____

□ Yes □ No Have you had an abnormal mammogram within the last year?

REASON FOR EXAM:

□ Routine □ Problem

□ Yes □ No Any **NEW** problems such as a lump, thickening, or nipple discharge? If yes, please describe.
Right_____ Left _____
_____ _____

BREAST SURGERY HISTORY:

□ Yes □ No Breast Implants Left _____ Right _____ Date: _____

□ Yes □ No Breast Reduction Left _____ Right _____ Date: _____

□ Yes □ No Needle Biopsy Left _____ Right _____ Date: _____

□ Yes □ No Surgical Biopsy Left _____ Right _____ Date: _____

□ Yes □ No Have you ever been diagnosed with breast cancer? Please circle all that apply:
Lumpectomy Left or Right Date: _____
Mastectomy Left or Right Date: _____ Radiation Chemotherapy

MEDICAL HISTORY:

Age at menarche _____ Age at 1st child _____ # of pregnancies _____ # of live births _____
Age at menopause_____ Hormone Replacement Therapy? □ Yes □ No Length of use _____ years
Age at hysterectomy _____ □ never □ 5+ years □ less than 5 years □ Current user

Have you ever been diagnosed with: □ atypical hyperplasia □ LCIS □ Ovarian Cancer

□ Yes □ No Do you have history of previous chest radiation (mantel radiation for thyroid or lymphoma)? If yes, age____

□ Yes □ No Do you have history of **any** other cancer? If yes, what type? _____ Age _____

FAMILY HISTORY OF CANCER:

Please indicate any of your relatives that have been diagnosed with breast cancer or ovarian cancer:

RELATIVE	Circle: RELATED FROM WHAT SIDE OF FAMILY	Circle: TYPE OF CANCER	AGE DIAGNOSED
	Mother's / Father's	Breast / Ovarian	
	Mother's/ Father's	Breast / Ovarian	
	Mother's/ Father's	Breast / Ovarian	
	Mother's/Father's	Breast / Ovarian	
	Mother's/Father's	Breast / Ovarian	

Are you of Eastern European (Ashkenazi) Jewish ancestry? □Yes □ No

Have you or any member or your family had genetic testing? □ Yes □ No

If yes, what genetic test, who underwent testing and what were the results? _____

PLEASE READ AND SIGN BELOW:

1. **I understand that mammography cannot detect all breast cancers. I understand that I should have yearly examinations by my doctor in addition to undergoing mammography and performing breast self-examinations.**
2. **This facility is required by the FDA to audit mammography outcomes. To help accomplish this, I give my permission to St Anthony Hospital to give or receive medical information and to give or receive mammography films to/from other physicians and medical facilities involved in my care.**
3. **Follow up diagnostic studies and treatments vary depending on individual radiographic evaluation and clinical situations. I understand that it is my obligation to follow my referring doctor's advice concerning follow up diagnostic studies, biopsies, or therapy.**

Patient's Signature: _____ **Date:** _____