NORTHERN LIGHTS
IMAGING

MRI SCREENING FORM

HEIGHT _____ WEIGHT _____

What symptoms prompted your visit today? _____

1.	Cardiac Pacemaker/Implanted Cardiovascular Defibrillator (ICD)/Heart valve/Heart Surgery:	YES	NO
	If yes, date/type: _____		
2.	Shunts/Stents/Intravascular coil: **if yes, date/type**: _____	YES	NO
3.	Ear or Eye Implants/ Surgery: **If yes, date/type**: _____	YES	NO
4.	Injury to eye involving metal or metal shavings	YES	NO
5.	Brain surgery or aneurysm clips: **if yes, date/type** _____	YES	NO
6.	Any electrical, mechanical, magnetic pumps, stimulators, and/or implants?	YES	NO
	If yes, date/type _____		
7.	Are you breastfeeding?	YES	NO
8.	Any body piercing jewelry?	YES	NO
9.	Any breast tissue expanders? **If yes, date/type** _____	YES	NO
10.	Bullets, shrapnel or metal fragments in skin or body?	YES	NO
	If yes, specify _____		
11.	Dentures/Hearing Aid/Wig**: Please circle which applies**	YES	NO
12.	Any type of prosthesis (eye, penile, etc.) **If yes, date/type** _____	YES	NO
13.	History of cancer or tumors	YES	NO
14.	Please list Allergies (all) _____	YES	NO
15.	Respiratory, liver or blood disorders? **If yes, specify** _____	YES	NO
16.	Any metallic medication patches? **If yes, specify** _____	YES	NO
17.	Heart, Brain, Eye or Ear surgery? **If yes, date/type** _____	YES	NO
18.	Are you Diabetic?	YES	NO

If yes, are you wearing a glucose monitor? YES NO

ANY surgeries not mentioned above: _____ Date: _____

_____

Please list dates and locations of prior MRI imaging related to today's exam:

_____ Date: _____ _____ Date: _____

_____

Patient/Guardian Signature: _____ Date: _____

NLI TECH Initials _____