KONA
COMMUNITY HOSPITAL
79-1019 Haukapila Street
Kealakekua, Hawaii 96750

**Hawaii Health Systems Corporation - Department of Radiology**

**SHADED AREAS MUST BE COMPLETED**

## PATIENT SCREENING
**(To be completed by patient before MRI exam)**

Date_____ , 200 _____

Name: _____

Birthdate: _____ Age:_____ Gender: M F

Address: _____ Weight: _____ (lbs.)

Home Telephone: _____ Business Telephone:_____ SSN: _____

Physician:_____

Procedure:_____ OP_____ IP _____ RM _____

Diagnosis: _____

Clinical History: _____

_____

Have you ever had a surgical procedure or operation of any kind? Yes _____ No_____
If yes, please list all prior surgeries and approximate dates: _____
_____
_____
_____

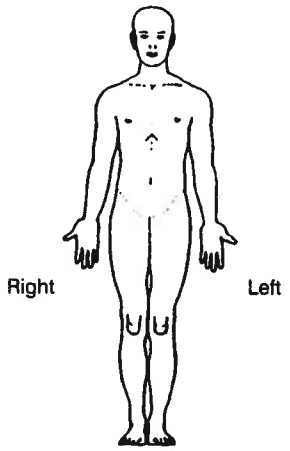
Are you pregnant or do you suspect that you are pregnant? Yes _____ No_____
Last menstrual period_____ /_____ /_____ Post menopausal_____ /_____ /_____ Hysterectomy_____ /_____ /_____
Has any metallic foreign body, e.g., bullet, BB, shrapnel, metal slivers, etc., ever injured you? Yes _____ No_____
If yes, where? _____

### THE FOLLOWING ITEMS MAY BE POTENTIALLY HAZARDOUS OR CONTRAINDICATED AND MAY INTERFERE WITH THE MRI EXAMINATION BY PRODUCING AN ARTIFACT

**Please indicate if you have any of the following:**

| | | |
|---|---|---|
| cardiac pacemaker | ☐ Yes | ☐ No |
| brain aneurysm clip(s) | ☐ Yes | ☐ No |
| implanted insulin pump | ☐ Yes | ☐ No |
| implanted drug infusion device | ☐ Yes | ☐ No |
| porta-cath | ☐ Yes | ☐ No |
| bone-growth stimulator | ☐ Yes | ☐ No |
| neurostimulator (TENS unit) | ☐ Yes | ☐ No |
| any type of bio-stimulator | ☐ Yes | ☐ No |
| any type of internal electrode(s) including pacing wires | ☐ Yes | ☐ No |
| internal hearing aid | ☐ Yes | ☐ No |
| cochlear implant | ☐ Yes | ☐ No |
| any type of electric, mechanical or magnetic implant | ☐ Yes | ☐ No |
| any metallic foreign body, shrapnel or bullet | ☐ Yes | ☐ No |
| Swan-Ganz catheter | ☐ Yes | ☐ No |
| Halo vest or metallic fixation device | ☐ Yes | ☐ No |

Please mark on the diagram the location of any metal inside of your body.



| | | |
|---|---|---|
| vascular clip(s) | ☐ Yes | ☐ No |
| hemostatic clip(s) | ☐ Yes | ☐ No |
| any type of surgical clip or staple(s) | ☐ Yes | ☐ No |
| orbital/eye prosthesis | ☐ Yes | ☐ No |
| wire suture(s) | ☐ Yes | ☐ No |
| any type of implant held in place by a magnet | ☐ Yes | ☐ No |
| any other implanted item | ☐ Yes | ☐ No |
| type | ☐ Yes | ☐ No |
| heart valve prosthesis | ☐ Yes | ☐ No |
| any type of ear implant | ☐ Yes | ☐ No |
| penile prosthesis | ☐ Yes | ☐ No |
| tattooed eyeliner | ☐ Yes | ☐ No |
| lens implant held in place by metallic structure | ☐ Yes | ☐ No |
| Diaphragm | ☐ Yes | ☐ No |
| IUD | ☐ Yes | ☐ No |
| renal stent | ☐ Yes | ☐ No |
| intraventricular stent | ☐ Yes | ☐ No |
| wire mesh | ☐ Yes | ☐ No |
| artificial limb or joint | ☐ Yes | ☐ No |
| any implanted orthopedic item(s), e.g., pins, rods, screws, nails, clips, plates, wire, etc. | ☐ Yes | ☐ No |
| dentures | ☐ Yes | ☐ No |
| dental braces | ☐ Yes | ☐ No |
| any type of removable dental item | ☐ Yes | ☐ No |
| wig | ☐ Yes | ☐ No |

**PERTINENT PREVIOUS STUDIES**

**Please note dates and location of previous studies, if known.**

X-rays _____

CT _____

Nuclear medicine _____

MRI _____

**I attest that the above information is correct to the best of my knowledge. I have read and understand the entire contents of this form and have had the opportunity to ask questions regarding the information on this form.**

Patient's Signature **X** _____ Date _____

Print Name of MD/RN/RT _____ Date _____

MD/RN/RT Signature _____ Date _____