

MRI Screening Questionnaire

Date: _____ Name: _____ DOB: _____ Male Female
LAST FIRST MIDDLE INITIAL

1. Have you had prior surgery or an operation (e.g. arthroscopy, endoscopy, etc.) of any kind? Y N
If yes, please indicate the date and type of surgery
 Date: _____ Type of surgery: _____
 Date: _____ Type of surgery: _____
2. Have you experienced any problem related to a previous MRI examination or MR procedure? Y N
If yes, please describe: _____
3. Have you had an injury to the eye involving a metallic object or fragment (e.g. metallic slivers, shavings, foreign body, etc)? Y N
If yes, please describe: _____
4. Have you ever been injured by a metallic object or foreign body (e.g. BB, bullet, shrapnel, etc.)? Y N
If yes, please describe: _____

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 questions or concerns 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:

- | | |
|--|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N Aneurysm clip(s)
<input type="checkbox"/> Y <input type="checkbox"/> N Cardiac pacemaker
<input type="checkbox"/> Y <input type="checkbox"/> N Implanted cardioverter defibrillator (ICD)
<input type="checkbox"/> Y <input type="checkbox"/> N Electronic implant or device
<input type="checkbox"/> Y <input type="checkbox"/> N Magnetically-activated implant or device
<input type="checkbox"/> Y <input type="checkbox"/> N Neurostimulation system
<input type="checkbox"/> Y <input type="checkbox"/> N Spinal cord stimulator
<input type="checkbox"/> Y <input type="checkbox"/> N Internal electrodes or wires
<input type="checkbox"/> Y <input type="checkbox"/> N Bone growth/bone fusion stimulator
<input type="checkbox"/> Y <input type="checkbox"/> N Cochlear, otologic or other ear implant
<input type="checkbox"/> Y <input type="checkbox"/> N Insulin or other infusion pump
<input type="checkbox"/> Y <input type="checkbox"/> N Implanted drug infusion device
<input type="checkbox"/> Y <input type="checkbox"/> N Any type of prosthesis (eye, penile, etc.)
<input type="checkbox"/> Y <input type="checkbox"/> N Heart valve prosthesis
<input type="checkbox"/> Y <input type="checkbox"/> N Eyelid spring or wire
<input type="checkbox"/> Y <input type="checkbox"/> N Artificial or prosthetic limb
<input type="checkbox"/> Y <input type="checkbox"/> N Metallic stent, filter, or coil
<input type="checkbox"/> Y <input type="checkbox"/> N Shunt (spinal or intraventricular) | <input type="checkbox"/> Y <input type="checkbox"/> N Vascular access port and/or catheter
<input type="checkbox"/> Y <input type="checkbox"/> N Radiation seeds or implants
<input type="checkbox"/> Y <input type="checkbox"/> N Swan-Ganz or thermodilution catheter
<input type="checkbox"/> Y <input type="checkbox"/> N Medication patch (Nicotine, Nitroglycerine)
<input type="checkbox"/> Y <input type="checkbox"/> N Any metallic fragment or foreign body
<input type="checkbox"/> Y <input type="checkbox"/> N Wire mesh implant
<input type="checkbox"/> Y <input type="checkbox"/> N Tissue expander (e.g. breast)
<input type="checkbox"/> Y <input type="checkbox"/> N Surgical staples, clips or metallic sutures
<input type="checkbox"/> Y <input type="checkbox"/> N Joint replacement (hip, knee, etc.)
<input type="checkbox"/> Y <input type="checkbox"/> N Bone/joint pin, screw, nail, wire, plate, etc.
<input type="checkbox"/> Y <input type="checkbox"/> N IUD, diaphragm, or pessary
<input type="checkbox"/> Y <input type="checkbox"/> N Dentures or partial plates
<input type="checkbox"/> Y <input type="checkbox"/> N Tattoo or permanent makeup
<input type="checkbox"/> Y <input type="checkbox"/> N Body piercing jewelry
<input type="checkbox"/> Y <input type="checkbox"/> N Hearing aid
<input type="checkbox"/> Y <input type="checkbox"/> N Breathing problem or motion disorder
<input type="checkbox"/> Y <input type="checkbox"/> N Claustrophobia
<input type="checkbox"/> Y <input type="checkbox"/> N Other implant: _____ |
|--|---|

IMPORTANT INSTRUCTIONS: Please remove all metallic objects before entering the MR room. This includes: hearing aids, beepers, cell phones, keys, eyeglasses, hair pins, barrettes, jewelry, ear and other body peircings, watches, safety pins, paperclips, money clips, credit and other magnetic strip cards, coins, pens, pocket knives, nail clippers, steel-toed shoes/boots, and tools. **PLEASE CONSULT THE MR TECHNOLOGIST OR RADIOLOGIST IF YOU HAVE ANY QUESTIONS OR CONCERNS BEFORE ENTERING THE MR ROOM.**

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: _____

Form completed by: Patient Relative Nurse _____

MRI Technologist (Print): _____ (Signature): _____

Level I or II Staff (Print): _____ (Signature): _____