THE RADIOLOGY CLINIC

MRI SCREENING QUESTIONNAIRE

Name: ______________________ **Age:** ____ **Procedure:** ______________________

Height: ____________ **Weight:** ____________ **Exam Date:** ______________________

Do you have or have you ever had any of the following:

Check Yes or No		Condition
☐ YES	☐ NO	Cardiac pacemaker or implanted cardioverter defibrillator/ICD
☐ YES	☐ NO	Internal electrodes or wires (pacing wires, DBS or VNS wires)
☐ YES	☐ NO	Artificial heart valve, coil, filter, IVC, and/or stent
☐ YES	☐ NO	Aneurysm clip or any other brain surgery
☐ YES	☐ NO	Neurostimulator-TENS Unit, Biostimulator, bone growth stimulator, DBS, VNS
☐ YES	☐ NO	Implanted/External drug pump, including insulin pump
☐ YES	☐ NO	IV access port (Port-a-cath, Mediport, Broviac, PICC line, Swan-Gantz, Thermodilution)
☐ YES	☐ NO	Implanted post-surgical hardware or joint replacement (pins, screws, rods, plates, wires)
☐ YES	☐ NO	Artificial eye and/or eye spring
☐ YES	☐ NO	Eye injury from a metal object and/or welding (metal shavings, metal slivers)
☐ YES	☐ NO	Hearing aid, Ear (Cochlear) implant, middle ear implant
☐ YES	☐ NO	False teeth/dentures, metallic removable dental work, braces, retainers
☐ YES	☐ NO	Injured by a metal object (shrapnel, bullet, BB)
☐ YES	☐ NO	Medication patch (nitroglycerine, nicotine, contraceptive, estrogen)
☐ YES	☐ NO	Shunt or Sophy programmable pressure valve
☐ YES	☐ NO	Spinal fixation device, spinal fusion, and/or halo vest, spinal cord stimulator
☐ YES	☐ NO	Surgical clips, staples, or surgical mesh
☐ YES	☐ NO	Tissue expander (breast)
☐ YES	☐ NO	Penile Implant
☐ YES	☐ NO	IUD, Pessary, Diaphragm
☐ YES	☐ NO	Radiation seeds (cancer treatment)
☐ YES	☐ NO	Body piercing, Tattoo or permanent makeup
☐ YES	☐ NO	Claustrophobia

Please List any Allergies:____

For women only:

Are you pregnant or is there any chance you could be pregnant?	☐ Unsure	☐ YES	☐ NO
Are you breast-feeding?		☐ YES	☐ NO
Are you wearing an underwire bra?		☐ YES	☐ NO

Instructions to Patient:

1. REMOVE ALL JEWELRY (E.G. NECKLACES, PINS, RINGS)
2. REMOVE ALL HAIR PINS, BOBBY PINS, BARRETTES, CLIPS, ETC.
3. REMOVE HEARING AIDS.
4. REMOVE WALLET, CREDIT CARDS, CELL PHONES, COINS, ETC.
5. REMOVE POCKET KNIVES, PAPER CLIPS, OR OTHER METAL OBJECTS.

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 I have the opportunity to ask questions regarding the information on this form.

Patient/Guardian Signature: ______________________________ Date: ____________

Witness Signature: ______________________________ Date: ____________