

Patient Name: _____

Age: _____ DOB: _____

Weight: _____ Height: _____

Date of Exam: _____

PATIENT IDENTIFICATION

MRI SCREENING QUESTIONNAIRE: PATIENT

**For your safety, all metallic objects must be removed prior to your MRI exam.
For any implanted devices, please present your implant card for review.**

LIST ALL PAST SURGERIES (including orthopedic/joint pins, wires):

Cardiac Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Claustrophobic	<input type="checkbox"/> Yes <input type="checkbox"/> No
Implanted Cardiac Defibrillator	<input type="checkbox"/> Yes <input type="checkbox"/> No	Allergy to MRI Contrast Describe:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pacer Wires	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pregnant Breastfeeding	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valve	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease Dialysis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
Cardiac stents	<input type="checkbox"/> Yes <input type="checkbox"/> No	Penile implant Prostate or other radiation seeds	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
Eyelid Spring or Retinal Tacks	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tissue Expanders (Breast or other) Tracheotomy	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
Cochlear or Other Ear Implants	<input type="checkbox"/> Yes <input type="checkbox"/> No	Endoscopy Camera and/or Pill Date swallowed:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tattoos, Tattoo Eye or Lip Liner	<input type="checkbox"/> Yes <input type="checkbox"/> No	Brain Aneurysm Clip Date:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Metal in Eye Describe:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Neurostimulator Spine stimulator	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
Bullets, BBs, Shrapnel Describe:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Spinal or ventricular Shunt	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any Implanted Drug Pumps Describe:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Any Other Implanted Metal or Device Date: Type:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diaphragm / IUD Bladder ring	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	Any Other Coils, Filters, or Stents Describe:	<input type="checkbox"/> Yes <input type="checkbox"/> No

If you responded "Yes" to any of the items below, for your safety, the items **MUST be removed.**

Hearing Aid	<input type="checkbox"/> Yes <input type="checkbox"/> No	False Teeth or Partial Plate	<input type="checkbox"/> Yes <input type="checkbox"/> No
Medication Patch/Metal dressing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Body Piercing	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Limb	<input type="checkbox"/> Yes <input type="checkbox"/> No	Wig, Hair Implants, Clips or Pins	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial limb electronics	<input type="checkbox"/> Yes <input type="checkbox"/> No	Insulin Pump or glucose monitor	<input type="checkbox"/> Yes <input type="checkbox"/> No

COMMENTS:

Form completed by: Patient Parent (required if age 17 and under) Clinician Other _____

Signature of Person Completing Form _____ Printed Name of Person Completing Form _____ Date _____ Time _____

MRI: Approved Conditional Not approved See device screening form for details

MRI Level II Signature _____ MRI Level II Printed Name _____ Date _____ Time _____

