# MRI Screening Questionnaire

Patient Name:_________________________ Date of Birth:__________ Weight:______ Height:______
Medication Allergies:_________________________________________________

**Warning:** Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MRI procedure. Do not enter the MRI room if you have any question or concern regarding an implant, device, or object. Consult the MRI Technologist BEFORE entering the MRI room.

**THE MRI SYSTEM MAGNET IS ALWAYS ON!**

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

| | Yes | No |
|---|---|---|
| **Cardiac pacemaker / Defibrillator** | | |
| **Are you claustrophobic?** | | |
| Cerebral Aneurysm clips | | |
| Shunt (spinal or intraventricular) | | |
| Brain surgery | | |
| Aneurysm clips | | |
| Bone Growth/Bone Fusion stimulator | | |
| Spinal cord or nerve stimulator | | |
| Magnetically-activated implant or device | | |
| Insulin or other drug infusion pump | | |
| Internal electrodes or wires | | |
| Other electronic implant device | | |
| Tissue expander (e.g. breast) | | |
| Joint replacement (hip, knee, etc.) If yes, where?__________ | | |
| PillCam endoscope device | | |
| Any type of prosthesis (eye, penile, other implant) | | |
| Vascular access port and/or catheter | | |
| Swan-Ganz or Thermodilution catheter | | |
| Shrapnel fragment or bullet injury | | |
| Have you ever been a metal worker? | | |

| | Yes | No |
|---|---|---|
| Have you had Feraheme Treatments? If yes, when?__________ | | |
| Medication patch (includes nicotine, thermo, Foil, etc.) | | |
| Body piercing jewelry | | |
| Artificial or prosthetic limb:________ | | |
| House arrest bracelet | | |
| Pregnant or breastfeeding | | |
| Active menstrual cycle (Breast MRI only) Date of last:__________ | | |
| History of Diabetes | | |
| History of impaired kidney function | | |
| History of cancer or myeloma | | |
| High blood pressure | | |
| Eyelid spring or wire | | |
| Have you ever had metal removed from your eyes? | | |
| Hearing Aid | | |
| Cochlear, otologic, or other ear implant | | |
| Previous MRI of scan area If yes, where?__________ | | |

**I understand: (Patient/patient caregiver to *INITIAL* indicating understand of)**

________ If I am pre-medicated, I will have a driver to be responsible in driving me home.
________ I will be given ear plugs/hearing protection to prevent possible hazards related to acoustic noise.
________ If I request to be removed from the scanner, the exam will be ended and the information obtained may not be enough for the radiologist to make a complete interpretation of the findings.
________ I have removed any credit cards, watches, knives, or any other metallic or sensitive electronic devices (i.e. **Hearing aids**) from my body and out of my pockets.

Have you had any surgery on the area being scanned? Y N

List all surgeries:_________________________________________________

Complaint or reason for exam:_________________________________________________

_________________________________________________

**Person completing questionnaire (signature):X**_________________________ **Date:**__________

Relationship to patient:_________________________