

MRI Screening Questionnaire

Patient Name: _____

Sex: _____

Age: _____

Weight: _____

This questionnaire is designed to assist us in determining if it is safe for you to undergo a magnetic resonance imaging procedure. It is important that you answer all of the following questions. **If you don't understand any question, please ask for assistance.**

1. Do you have a pacemaker, wires, defibrillator or implanted heart valves? Yes No Don't Know
2. Have you ever had any head surgery requiring aneurysm clips? Yes No Don't Know
3. Have you ever had any type of surgery? Yes No Don't Know
4. Have you ever had a reaction to a contrast agent used for MRI, CT or X-ray? Yes No Don't Know
5. Do you have any surgically implanted metal of any type in your body? Yes No Don't Know
6. Have you ever been exposed to metal fragments that could be lodged in your eyes or body? Yes No Don't Know
7. Do you have a hearing aid, middle/inner ear prosthesis, dentures or bridges? Yes No Don't Know
8. Do you have any metal pin, joint, prosthesis or metallic object in, or attached to your body? Yes No Don't Know
9. Do you have any type of electronic device (stimulator or pump) implanted in your body? Yes No Don't Know
10. Do you have or have you ever had tattoos, permanent eyeliner or lipliner, or body piercing? Yes No Don't Know
11. Are you wearing a transdermal drug patch? What kind? _____ Yes No Don't Know
12. Do you have a history of panic attacks or a fear of enclosed or narrow spaces? Yes No Don't Know
13. Do you have a history of drug or food allergies? Yes No Don't Know
14. Do you have a history of renal (kidney) disease, seizure, asthma, or emphysema? Yes No Don't Know
15. Are you pregnant, or is it possible that you may be pregnant? Yes No Don't Know
16. Are you breastfeeding? Yes No Don't Know
17. Is there any other item or device you believe we should know about prior to performing the MRI - if yes please describe:

I certify that I have read and understood the questions asked in this questionnaire and that the above responses are correct to the best of my knowledge. I understand that it is my responsibility to inform the Center of any metal fragments and/or devices that may be in my body and that by failing to do so may cause serious bodily injury or be life threatening. I agree that should I have any metal in my body and, after consultation with a physician, elect to proceed with the MRI, I agree to release Center from any and all liability for any injury.

Patient or Legal Representative Signature

Print Name and Authority (if legal representative)

Date

Witness or Interpreter Signature

Print Name

Date

Physician/Registered Nurse/Technologist

Print Name

Date

Technologist Notes: