MRI Screening Questionnaire

☐ Male
☐ Female

Date _____ / _____ / _____ Name _____ DOB _____

LAST FIRST MIDDLE INITIAL

1. Have you had prior surgery or an operation (e.g. arthroscopy, endoscopy, etc.) of any kind? ☐ **Yes** ☐ **No**

   If "Yes", please indicate the date and type of surgery

   Date: ___/___/____ Surgery:_____

   Date: ___/___/____ Surgery:_____

   Date: ___/___/____ Surgery:_____

2. Have you experienced any problem related to a previous MRI exam or MR procedure? ☐ **Yes** ☐ **No**

   *If "Yes", please describe:*_____

3. Do you have any allergies to food, drugs, or latex? ☐ **Yes** ☐ **No**

   *If "Yes", please describe:*_____

4.

   A. Have you had an eye injury involving a metal (e.g. metallic slivers, shavings, foreign body, etc.) ☐ **Yes** ☐ **No**

   B. Have you ever been injured by a metallic object or fragment (e.g. bullet, BB, shrapnel, etc.?) ☐ **Yes** ☐ **No**

   C. Have you ever performed: Welding; Grinding; Machine Work; Metal Lathe work? ☐ **Yes** ☐ **No**

   If "Yes" to A, B, and/or C, please describe: _____

5. Have you had a colonoscopy or upper endoscopy ("EGD") within the past 3 months? ☐ **Yes** ☐ **No**

   If "Yes", were any clips placed? ☐ **Yes** ☐ **No** ☐ **Don't Know**

6. If applicable:

   A. Start date of last menstrual period? _____

   B. Are you currently Pregnant or Breastfeeding ☐ **Yes** ☐ **No** ☐ **N/A**

Please indicate if you have any of the following:

☐ **Yes**	☐ **No**	Aneurysm clip(s)	☐ **Yes**	☐ **No**	Vascular access port and/or catheter
☐ **Yes**	☐ **No**	Pacemaker or defibrillator (ICD)	☐ **Yes**	☐ **No**	Radiation seeds or implants
☐ **Yes**	☐ **No**	Any metallic fragment or foreign body	☐ **Yes**	☐ **No**	Swan-Ganz or thermodilution catheter
☐ **Yes**	☐ **No**	Electronic implant or device	☐ **Yes**	☐ **No**	Medication patch (nicotine, nitroglycerine, etc.)
☐ **Yes**	☐ **No**	Joint replacement (hip, knee, etc.)	☐ **Yes**	☐ **No**	Wire mesh implant
☐ **Yes**	☐ **No**	Neurostimulator device	☐ **Yes**	☐ **No**	Tissue expander (e.g. breast)
☐ **Yes**	☐ **No**	Internal electrodes or wires	☐ **Yes**	☐ **No**	Surgical staples, clips, or metallic sutures
☐ **Yes**	☐ **No**	Bone growth / bone fusion stimulator	☐ **Yes**	☐ **No**	Bone / joint pin, screw, nail, wire, plate, etc.
☐ **Yes**	☐ **No**	Cochlear, otologic, or other ear implant	☐ **Yes**	☐ **No**	IUD, diaphragm, or pessary
☐ **Yes**	☐ **No**	Implanted drug infusion (e.g. insulin, pain meds)	☐ **Yes**	☐ **No**	Glucose monitor
☐ **Yes**	☐ **No**	Any type of prosthesis (eye, penile, etc.)	☐ **Yes**	☐ **No**	Dentures or partial plates
☐ **Yes**	☐ **No**	Heart valve prosthesis	☐ **Yes**	☐ **No**	Tattoo or permanent makeup
☐ **Yes**	☐ **No**	Eyelid spring or wire	☐ **Yes**	☐ **No**	Body piercing jewelry
☐ **Yes**	☐ **No**	Artificial or prosthetic limb	☐ **Yes**	☐ **No**	Hearing aid
☐ **Yes**	☐ **No**	Metallic stent, filter, or coil	☐ **Yes**	☐ **No**	Breathing problem or motion disorder
☐ **Yes**	☐ **No**	Shunt (spinal or intraventricular)	☐ **Yes**	☐ **No**	Claustrophobia
☐ **Yes**	☐ **No**	Spinal Fusion Procedure or Fixation Device	☐ **Yes**	☐ **No**	Other implant _____
☐ **Yes**	☐ **No**	Cosmetic attachments (wig, hair implants, magnetic eyelashes, etc.)			

IMPORTANT INSTRUCTIONS: Please remove all metallic objects before entering the MRI room. This includes: hearing aids, beepers, cell phones, keys, eyeglasses, hair pins, barrettes, jewelry, ear/body piercings, watches, safety pins, paperclips, money clips, magnetic strip cards (credit cards, etc.), coins, pens, pocket knives, nail clippers, steel-toed shoes, and tools.
WARNING: The MRI magnet is ALWAYS ON. Certain implants, devices, and other objects can be hazardous to you or interfere with the MRI study. DO NOT ENTER the MRI scanner room or MRI environment if you have any questions or concerns – instead, consult the MRI Technologist.

I attest that the above information is correct to the best of my knowledge. I have read and I understand the contents of this form, and have had the opportunity to ask questions about it and about the MR exam that I am about to undergo.

Signature of person completing form: _____ Date _____ / _____ / _____ Relationship: ☐ Patient ☐ Relative ☐ Other

MRI Technologist _____ _____
PRINT NAME SIGNATURE