

## 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. **I you don't understand any question, please ask for assistance.**

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

The greatest risk is a metallic object flying through the air toward the magnet and hitting you. To reduce this risk we require that all people involved with the study removed all metal from their clothing and all metal objects from their pockets. No metal objects are allowed to be brought into the magnet room at any time. In addition, once you are in the magnet, the door to the room will be closed so that no one inadvertently walks into the magnet.

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	Printed Name	Date