Today's Date: ________________ Patients Name: ___________________________________
Patient height: ____________cm/in Patients Weight: ________kg/lb Date of Birth: ________

1. Do you have a **Pacemaker / Defibrillator**?
   ☐ Yes ☐ No

2. Do you have anything implanted in your body you were not born with?
   ☐ Yes ☐ No
   a. Please explain: ____

3. Do you suspect you are **pregnant**?
   ☐ Yes ☐ No

4. Do you have a **Breast Tissue Expander** in place?
   ☐ Yes ☐ No **(Patients with these devices are never to be scanned)**

5. Do you experience claustrophobia?
   ☐ Yes ☐ No

6. Have you ever had an aneurysm repair?
   ☐ Yes ☐ No
   a. Please explain: ____

7. Do you have anything implanted in your body such as; a spinal neurostimulator, deep brain stimulator, programmable shunt / stent, abdominal mesh.
   ☐ Yes ☐ No
   a. Please explain: ____

8. Do you have any devices, included, but not limited to; pain pump, insulin pump, artificial extremity or hearing aids.
   ☐ Yes ☐ No
   a. Please explain: ____

9. Do you have a Spinal fixation device?
   ☐ Yes ☐ No

10. Do you have any internal ear implants?
    ☐ Yes ☐ No

11. Have you ever had surgery outside of the United States?
    ☐ Yes ☐ No
    In what country: __________________ Year: ______ Body Part: _____________

12. Are you a diabetic?
    ☐ Yes ☐ No

13. Are you wearing a medication patch, or any type of medication injector device?
    ☐ Yes ☐ No
    a. Glucose Monitor, Estrogen Patch, Neulasta Patch (Oncology)
    b. Please explain: ____

Please complete page 2 of this form

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MRI SCREENING QUESTIONNAIRE (ENGLISH)

14. Have you ever been shot? Is the bullet or shrapnel still within your body?
☐ Yes ☐ No Please explain: ____

15. Do you presently have a pill cam, a vibrating pill (Vibrant), Loop recorder, or a Linx Reflux Management System?
☐ Yes ☐ No

16. Have you ever gotten metal in your eyes or done welding, sheet metal and/or torch cutting?
☐ Yes ☐ No

17. If so, did you ever require medical attention to remove metal from your eyes?
☐ Yes ☐ No Please explain: ____________________________________

18. Do you have any tattoos, permanent eyeliner, or hair extensions?
☐ Yes ☐ No (If Yes, circle applicable item)

19. Do you wear cosmetic colored contact lenses?
☐ Yes ☐ No If yes, which do you use? ☐ Standard ☐ Color

20. Do you wear braces, dentures, or dental expanders?
☐ Yes ☐ No (If Yes, circle applicable item)

21. Do you have body piercings?
☐ Yes ☐ No Please provide location: ___________________________________

22. Do you have a history of high blood pressure?
☐ Yes ☐ No
a. Are you on medication to correct high blood pressure?
☐ Yes ☐ No

23. Do you have any Kidney issues?
☐ Yes ☐ No
a. Poorly functioning kidneys, kidney disease, removal of or partial removal of a kidney
b. Please explain: ____

24. Are you on Dialysis?
☐ Yes ☐ No If Yes, when is your next dialysis scheduled: ____________

25. Do you have an internal contraceptive device?
☐ Yes ☐ No If Yes, list Type: __________________________________

26. Do you have a Pessary?
☐ Yes ☐ No

27. Do you have a Penile Implant?
☐ Yes ☐ No

I or my representative have read and answered the MRI screening form questionnaire. The form has been reviewed by the MRI staff. By signing this form I agree to this examination.

Patient Signature: ______________________________________ Date: _______
Patient Representatives Signature: ______________________________ Date: _______
Technologist / Nurse Signature: _______________________________ Date: _______

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