

MRI Screening Questionnaire

Patient Name: _____ Date: _____ 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 <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 or dentures? | 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, tattooed eyeliner, lipliner or body piercing? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Don't Know <input type="checkbox"/> |
| 11. Do you wear a transdermal patch (nitroglycerin or nicotine)? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Don't Know <input type="checkbox"/> |
| 12. Do you have a history of panic attacks or a fear of enclosed or narrow places? | 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 a history of renal disease, seizure, asthma, or emphysema? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Don't Know <input type="checkbox"/> |
| 15. If you are a woman – are you pregnant, or is it possible that you might be pregnant? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Don't Know <input type="checkbox"/> |
| 16. If you are a woman – are you breastfeeding? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| 17. Is there any other item or device you believe we should know about prior to performing the procedure – 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 **Spencer Open MRI 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 **Spencer Open MRI** from any and all liability for any injury.**

Patient or Legal Representative Signature

Print Name and Authority (if legal representative)

Date

Interpreter Signature (If Needed)

Print Name

Date

Technologist

Title

Date

Technologist Notes: _____
