# MRI Screening Questionnaire

MRN# DOB:

Patient Name: Date:

Provider:

Name: ______________________________________________________ Gender: Female ☐ Male ☐

DOB: _____ /_____ /______ Age: ________ Weight: __________ lbs. Height:___________ (feet/inches)

1. **Have you had any surgery, operation, or endoscopy, colonoscopy of any kind?** ☐ YES ☐ NO

If yes, indicate date and type of procedure:____________________________________________________________________

2. **Do you, or have you ever had a pacemaker, implanted defibrillator, or aneurysm clips/coil?** ☐ YES ☐ NO
3. **Have you had a prior diagnostic imaging study or examination (MRI, CT, XRAY, Ultrasound)?** ☐ YES ☐ NO
   - ☐ If yes, please list:_______________________________________________________________________________
4. **Have you had an injury to the eye involving metallic objects or fragments?** ☐ YES ☐ NO
   - ☐ If yes, please explain:___________________________________________________________________________
5. **Do you have a history of asthma, allergic reaction, respiratory disease, or reaction to a contrast medium or dye used for an MRI, CT, or XRAY?** ☐ YES ☐ NO
6. **Do you have anemia or any kidney disease(s) that affect your blood, a history of renal(kidney) disease, renal failure, kidney transplants, high blood pressure, liver disease, any history of diabetes?** ☐ YES ☐ NO
7. **Are you Claustrophobic?** ☐ YES ☐ NO
   - ☐ If yes, are you taking medication for todays exam? ☐ YES ☐ NO
8. **Reason for todays exam**:_______________________________________________________________________________

**Female Patients Only:**

1. Start date of last menstrual cycle: _____ /_____ /______
2. Are you pregnant or think you may be pregnant? ☐ YES ☐ NO
3. Are you breastfeeding? ☐ YES ☐ NO
4. Are you taking any oral contraceptives or hormone replacement therapy (HRT)? ☐ YES ☐ NO
5. Are you taking any type of fertility medication or having fertility treatment? ☐ YES ☐ NO

| **Please indicate if you have any of the following:** | | | | | |
|---|---|---|---|---|---|
| Aneurysm clip(s) | YES | NO | Surgical staples, clips, or metallic sutures | YES | NO |
| Cardiac pacemaker and/or Implanted | YES | NO | Joint replacement (hip, knee, etc.) | YES | NO |



Form # 819 Created 5/2020

# MRI Screening Questionnaire

:

MRN#

DOB:

Patient Name:

Date:

Provider:

| | | | | | |
|---|---|---|---|---|---|
| cardioverter defibrillator (ICD) | | | | | |
| Electric device or implant | YES | NO | IUD, diaphragm, or pessary | YES | NO |
| Neurostimulation system | YES | NO | Dentures or partial plates | YES | NO |
| Internal electrodes or wires | YES | NO | Tissue expander (i.e., breast) | YES | NO |
| Bone growth/bone fusion stimulator | YES | NO | Tattoo or permanent makeup | YES | NO |
| Cochlear, otologic, or other ear implants | YES | NO | Body piercing jewelry | YES | NO |
| Insulin or other infusion pump | YES | NO | Breathing problem or motion disorder | YES | NO |
| Any type of prosthesis (eye, penile, etc.) | YES | NO | Hearing aid (***MUST*** *be removed before entering MRI exam room)* | YES | NO |
| Metallic stent, filter, or coil | YES | NO | Any clothing labeled 'anti-microbial, anti-bacterial, or anti-odor'? | YES | NO |
| Shunt (spinal or ventricular) | YES | NO | Any metallic fragment or foreign body? | YES | NO |
| Vascular access port and/or catheter | YES | NO | Other implant: ______________________ | YES | NO |
| Transdermal (skin) Medication patch | YES | NO | | | |

| | |
|---|---|
| **WARNING: Certain implants, devices or objects may be hazardous to you and or may interfere with the MR procedure (i.e., MRI, MR Angiography, MR Breast Biopsy). DO NOT ENTER the MRI room or MRI environment if you have any questions or concern regarding an implant, device, or object. Consult the MRI technologist, or Radiologist BEFORE entering MRI room. The MRI system magnet is ALWAYS ON.** | Technologist Note / Initials: |

**Please note: All patients are required to wear hearing protection (which we will provide) during their MRI exam. All patients are required to change into provided SMG apparel (gown, pant, etc.)**

**Signature**

*I understand and accurately answered all the safety questions on this form. I am also aware if I have taken medication to wither claustrophobia or pain in order to have my MRI, I cannot drive and must have someone drive me to and from the facility.*

______________________________________ ____________________

Patient Signature (or person authorized to sign for Patient) Date

______________________________________

Relationship to Patient if signing for Patient

______________________________________ ____________________

Interpreter Signature (or ID# if using service), as applicable Date



Form # 819 Created 5/2020