Screening Questionnaire

MAGNETIC RESONANCE IMAGING

Name____ Weight_______________lbs/kgs

The following items may interfere with the MRI scan, may be damaged by the magnetic field, or might be harmful to you if present.

HAVE YOU EVER WELDED/WORKED WITH METAL?	Y	N
HAVE YOU EVER HAD AN EYE INJURED BY METAL?	Y	N

Do you have any of the following?

Heart Pacemaker	Y	N
Heart Valve (any heart surgery?)	Y	N
Aneurysm Clip (Brain Surgery)	Y	N
ANY implanted electronic surgical device	Y	N

Specify____

Implanted Drug or Insulin Pump	Y	N
Bone Growth or Neuro Stimulator	Y	N
Ear Implant	Y	N
Hearing Aid	Y	N
Vascular Coil (ex. Coil in Brain Vessel)	Y	N
Any type of Internal Shunt	Y	N
Artificial Limb or Joint	Y	N
Any Orthopedic Item (screw, pin, wire, staple, plate, etc)	Y	N

Where ____

Penile Prosthesis	Y	N
Wire Mesh (ex. Hernia repair)	Y	N
Shrapnel or bullets	Y	N
Tattoos (including permanent eyeliner)	Y	N

Where and When____

Body Piercing	Y	N

Where____

Dentures (Complete or Partial) or any dental device	Y	N

Specify____

Any Nicotine or transdermal medical patches?	Y	N
ARE YOU CLAUSTROPHOBIC?	Y	N
DO YOU HAVE ANY ALLERGIES?	Y	N

Specify____

IF FEMALE:

Last Menstrual Period____

Could you be pregnant?	Y	N
Do you have an IUD (internal birth control device?)	Y	N

Do you have any specific concerns? __________________________________

Signature______________________

Date_________________________ Witness________________________

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