



MAGNETIC RESONANCE IMAGING (MRI) SCREENING FORM (pg 1)

Patient Name: \_\_\_\_\_

Height: \_\_\_\_\_

Weight: \_\_\_\_\_

Male  or Female:

Body Part or Area to be examined: (Brain, Abd, Knee etc?) \_\_\_\_\_

Reason for MRI and/or Symptoms: \_\_\_\_\_

Do you have pain or numbness?  Right Upper Extremity  Left Upper Extremity

Right Lower Extremity  Left Lower Extremity

1. Have you ever had an injury to the area to be examined?  Yes  No  
If yes, please describe: \_\_\_\_\_ Date of injury: \_\_\_\_\_

2. Have you had any surgery to area being imaged today?  Yes  No  
If yes, please indicate date of surgery. \_\_\_\_\_ Date of surgery: \_\_\_\_\_

3. Have you had a prior examination to area we are imaging today. If yes, please circle.  
MRI CT Scan Ultrasound X-Ray Angiogram PET  Yes  No

4. Have you recently had an injection to area being imaged today?  Yes  No  
If yes, please indicate date of injection. \_\_\_\_\_ Date of injection: \_\_\_\_\_

5. Are you Claustrophobic?  Yes  No

6. Have you ever been injured by a metal object or foreign body (e.g., bullet, BB, shrapnel)?  
If yes, please describe: \_\_\_\_\_  Yes  No

7. Have you ever had an injury to your eye from a metallic object (metal slivers, metal shavings) that required  
medical attention?  Yes  No  
If yes, please describe what was found: \_\_\_\_\_

8. Do you have a history of Diabetes?  Yes  No

9. Do you have a history of Cancer or Tumors?  Yes  No

10. Have you ever had Radiation or Chemotherapy?  Yes  No

**FOR FEMALE PATIENTS**

Are you pregnant or experiencing a late menstrual period?  Yes  No

**For Breast MRI Patients Only**

Date of last menstrual period:     /     /     Post menopausal?  Yes  No

**IMPORTANT INSTRUCTIONS. Before entering the MR room you must remove all metallic objects.**

Remove hearing aids and eyeglasses.

Remove all hairpins, bobby pins, barrettes, clips, etc.

Remove body piercing objects.

Remove all jewelry (e.g., necklaces, pins, earrings).

Remove your watch, pager, cell phone, credit cards, bank cards or other cards with magnetic strips.

Remove any pens, nail clippers, pocketknives, tools or safety pins.

Remove belts, clothing with metal fasteners or metallic threads.

**Please consult with the MRI Technologist if you have any questions or concerns before you enter the MRI scan room.**

**MAGNETIC RESONANCE IMAGING (MRI) SCREENING FORM (pg2)**



**The MRI system magnet is ALWAYS on.**

Do not enter the MR Scan room until you have reviewed this section for devices or implants that may be hazardous or may interfere with the MR procedure.

Please indicate if you have any of the following:

Aortic Aneurysm (AAA) Grafts	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Cardiac Pacemaker	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Pacing Wires or pacemaker that has been removed	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Implanted Cardioverter Defibrillator (ICD)	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Swan-Ganz or thermodilution catheter	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Heart valve Replacement	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Any type of electronic, mechanical or magnetic implant type:	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

Brain Aneurysm clip or coil type: _____ Date Implanted: _____	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
VNS - Vagal Nerve Stimulator	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

Eyelid spring or wire	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Permanent or tattooed eyeliner, mascara or other cosmetic	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Cochlear, otologic or other ear implant	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Hearing Aid	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Wig or hair implants	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Dentures, Braces or Partial Plate	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

Neurostimulator (for spinal or back pain)	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Spinal fixation device	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Implanted drug pump (e.g., insulin, Baclofen, chemotherapy)	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Shunt (spinal or intraventricular)	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Any type of internal electrodes or wires	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

Joint Replacement (e.g., hip, knee)	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Bone growth or fusion stimulator	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Pins, rods, screws, nails, plates or wires	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

Filters, coils or stents (for blood clots) type: _____ Date Implanted: _____	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Any IV access port (e.g., Port-a-Cath, Hickman, PICC line)	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Tissue expander (e.g., Breast)	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Surgical (wire) mesh implant	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Medication Patch (e.g., nicotine, nitroglycerine, pain medicine)	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Penile implant or prosthesis type: _____ Date Implanted: _____	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
At this time do you have an IUD, Diaphragm or pessary?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
A tattoo or body piercing jewelry <b>anywhere</b> on your body	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Any other type of implant type: _____ Date Implanted: _____	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

Date: / /

Authorized Signature(patient/family member or guardian or RN if done by phone)

MRI Technologist reviewing this form:

(signature of person bringing patient into the scan room)