



MRI PATIENT SCREENING QUESTIONNAIRE

patient label

Patient's Name: _____

Date of Birth: _____ Height: _____

Today's Date: ____/____/____

Please read the following form carefully. It is important for us to know if you have any metal in your body. If you have previous MRI / CT Scan / Ultrasound / Nuclear Medicine/ X-Ray, Please inform the Technologist or Aide. If for any reason you have questions please leave blank and ask us to explain!

Please indicate with check mark in the box if you have any of the following:
Please complete both sides of this form

1. Yes No Do you have a cardiac pacemaker or defibrillator?
(If you have a cardiac pacemaker or defibrillator you cannot have an MRI)
2. Yes No Do you have any aneurysm clips in your brain or previous brain surgery?
3. Yes No Have you ever had metal in your eyes or removed from your eyes?
4. Yes No Do you have a neuro-stimulator, bone growth stimulator, or Vagus Nerve stimulator?
5. Yes No Do you have any stents placed in your body? Where?_____.
6. Yes No Do you have an artificial heart valve / annuloplasty ring?
7. Yes No Do you have a hearing aid or inner ear implant (stapes or cochlear) ?
8. Yes No Do you have an insulin pump or any types of pumps?
9. Yes No Do you have an artificial limb?
10. Yes No Do you wear a patch to deliver medicines through your skin?
11. Yes No Have you ever had any shrapnel, gun shot, or BB wound located in your body? (If so where)?_____.
12. Yes No Do you have body-piercing or jewelry on your body?
13. Yes No Do you have programmable shunt ?
14. Yes No Do you have an eye prosthesis? (If so Left or Right)?
15. Yes No Have you ever had an allergic reaction to MRI contrast?
16. Yes No Can you walk without help?

PLEASE COMPLETE AND FAX TO (989) 907-7773, THANK YOU!

Continue on back of this form

