



Office Use Only

Room: _____

Exam: _____

PATIENT NAME: _____ WEIGHT _____

DOB: _____

GENDER Male Female

- 1. Have you ever had surgery in the area being scanned? Yes: No:
- 2. Have you ever had a prior study to the area being scanned? Yes: No:
- 3. Have you ever had Heart, Brain or ear surgery? Yes: No:
If Yes, please list: _____
- 4. Have you ever had metal in your eyes? Yes: No:
- 5. Do you have a history of Cancer? Yes: No:
If Yes, please list type: _____

	Yes	No
Cardiac Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac Stent/Filter	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac Defibrillator (ICD)	<input type="checkbox"/>	<input type="checkbox"/>
Pacing Wires	<input type="checkbox"/>	<input type="checkbox"/>
Heart Valves	<input type="checkbox"/>	<input type="checkbox"/>
Tissue Expander	<input type="checkbox"/>	<input type="checkbox"/>
Wire Mesh Implant	<input type="checkbox"/>	<input type="checkbox"/>
Inferior Vena Cava Filter	<input type="checkbox"/>	<input type="checkbox"/>
Aneurysm Clip	<input type="checkbox"/>	<input type="checkbox"/>
Brain Clips	<input type="checkbox"/>	<input type="checkbox"/>
Eyelid Spring or Wire	<input type="checkbox"/>	<input type="checkbox"/>
Cerebral Vascular Coils	<input type="checkbox"/>	<input type="checkbox"/>
Deep Brain Stimulator	<input type="checkbox"/>	<input type="checkbox"/>
Catheter	<input type="checkbox"/>	<input type="checkbox"/>
Medication Patch	<input type="checkbox"/>	<input type="checkbox"/>
Pins/ Nails/Screws	<input type="checkbox"/>	<input type="checkbox"/>
Nerve Stimulator	<input type="checkbox"/>	<input type="checkbox"/>
Infusion Pump	<input type="checkbox"/>	<input type="checkbox"/>
Neurostimulator	<input type="checkbox"/>	<input type="checkbox"/>
Radiation seeds or implants	<input type="checkbox"/>	<input type="checkbox"/>
Vascular access port/or catheter	<input type="checkbox"/>	<input type="checkbox"/>
Appendix Surgery	<input type="checkbox"/>	<input type="checkbox"/>
Gallbladder Surgery	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No
Aortic Clip	<input type="checkbox"/>	<input type="checkbox"/>
Shrapnel/Bullet(s)	<input type="checkbox"/>	<input type="checkbox"/>
Bone Stimulator	<input type="checkbox"/>	<input type="checkbox"/>
Joint Replacement	<input type="checkbox"/>	<input type="checkbox"/>
Joint Prosthesis	<input type="checkbox"/>	<input type="checkbox"/>
Stapes Ear Implant	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Aid (Remove before exam)	<input type="checkbox"/>	<input type="checkbox"/>
Bivona Metal Trach	<input type="checkbox"/>	<input type="checkbox"/>
Metal in Body	<input type="checkbox"/>	<input type="checkbox"/>
Cochlear Implant	<input type="checkbox"/>	<input type="checkbox"/>
Dentures/Partial Plates	<input type="checkbox"/>	<input type="checkbox"/>
Dental Braces	<input type="checkbox"/>	<input type="checkbox"/>
Shunts	<input type="checkbox"/>	<input type="checkbox"/>
Drug Pumps	<input type="checkbox"/>	<input type="checkbox"/>
Surgical staples/clips /metallic sutures	<input type="checkbox"/>	<input type="checkbox"/>
Tattoo's or permanent make-up	<input type="checkbox"/>	<input type="checkbox"/>
Body piercing jewelry	<input type="checkbox"/>	<input type="checkbox"/>
Retinal Tack	<input type="checkbox"/>	<input type="checkbox"/>
Other/Implants	<input type="checkbox"/>	<input type="checkbox"/>
Claustrophobia	<input type="checkbox"/>	<input type="checkbox"/>

FOR FEMALE PATIENTS	Yes	No
IUD (Mirena or Other)	<input type="checkbox"/>	<input type="checkbox"/>
Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Are you breastfeeding?	<input type="checkbox"/>	<input type="checkbox"/>
Hysterectomy?	<input type="checkbox"/>	<input type="checkbox"/>

X _____ DATE: _____

My signature indicates that I have read the patient screening form and I have had the opportunity to ask questions. I agree to have the MRI as indicated and a contrast injection if necessary. **WARNING:** If you have any questions or concerns regarding an implant, device, or object. Consult the MRI Technologist BEFORE entering the MR system room. **The MR system magnet is ALWAYS ON**