Community Health Network

MRI SCREENING QUESTIONNAIRE

Name: _____ Age: _____ Weight: _____ Date: _____ / _____ / _____

Patient safety is our primary concern. Some of the following items can interfere with Magnetic Resonance Imaging and some can be hazardous to your safety. Please carefully complete this questionnaire prior to your exam.

Do you have any of the following:

1. **Cardiac Pacemaker,** defibrillator, ICD or pacing wires ☐ Yes ☐ No
2. Heart valve replacement or cardiac stents ☐ Yes ☐ No
3. Any internal or external TENS Unit, nerve stimulator or device of any kind? ☐ Yes ☐ No
4. Any internal or external electronic pump and/or monitor (insulin, glucose, chemo, pain management, etc)? ☐ Yes ☐ No
5. Are you wearing an ankle bracelet or home detention monitor? ☐ Yes ☐ No
6. Have you ever had surgery on your brain or an intracranial aneurysm clip? ☐ Yes ☐ No
7. Intravascular stents, filters, coils, catheters or shunts of any kind? ☐ Yes ☐ No
8. Any type of ear surgery, ear implant or hearing aids? ☐ Yes ☐ No
9. Have you ever had surgery on your eyes? ☐ Yes ☐ No
10. Have you ever had metal in your eyes? ☐ Yes ☐ No
11. Do you have a wire mesh implant? ☐ Yes ☐ No
12. Dentures or removable dental work? ☐ Yes ☐ No
13. Are you breast feeding? ☐ Yes ☐ No
14. Are you pregnant? ☐ Yes ☐ No
15. Transdermal skin patch of any type? ☐ Yes ☐ No
16. Have you had surgery within the last six (6) weeks? ☐ Yes ☐ No
17. Do you have shrapnel, metal fragments, shavings or bullets in you? ☐ Yes ☐ No
18. Do you have any body piercings or tattoos? ☐ Yes ☐ No
19. **Any internal, external device or metal anywhere in/on your body?** ☐ Yes ☐ No
    _____
20. Do you have kidney disease/impairment, only one kidney or had a kidney transplant? ☐ Yes ☐ No
21. Have you had chemo in the last 30 days? ☐ Yes ☐ No
22. Do you have a history of multiple myeloma? ☐ Yes ☐ No
23. Are you diabetic? ☐ Yes ☐ No
24. Are you currently undergoing hemodialysis or peritoneal dialysis? ☐ Yes ☐ No
25. Have you had a MRI with IV contrast in the last 48 hours? ☐ Yes ☐ No
26. Have you ever had a reaction to MRI IV contrast? ☐ Yes ☐ No
27. Are you claustrophobic? ☐ Yes ☐ No
28. Are you able to lie flat? ☐ Yes ☐ No
29. Have you taken any medication for pain or anxiety prior to your MRI today? ☐ Yes ☐ No
30. Have you ever had cancer (if yes, what kind)? ☐ Yes ☐ No
    _____
31. Have you ever had a MRI, X-Ray or other imaging exam of this body part? ☐ Yes ☐ No
    If yes, specify type of exam, when & where:
    _____
    _____

Have you had prior surgery or an operation (e.g., arthroscopy, endoscopy, etc.) of any kind? If yes, please indicate the date and type of surgery below.

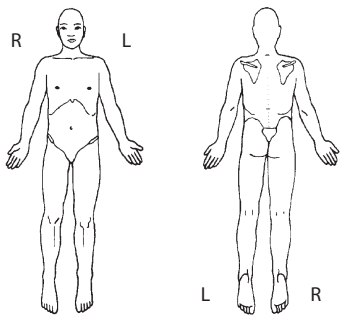
Type	Date	Type	Date

Please list your symptoms & date of occurrences and then shade the diagram at the right where your pain or numbness is located: _____

_____

_____

_____



I certify that the answers are true and correct to the best of my knowledge.

_____
Patient Signature Date/Time

I have reviewed the MRI contrast Medication Guide.

_____
Patient Signature Date/Time

_____
MRI Technologist Signature Date/Time

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