MRI Procedure Screening Questionnaire

Date: _____/_____/______   MRN: _______________________

Name: ____________________________________________________________
Age: ______ Gender: M / F
DOB: ____/____/_______ Height: __________ Weight: ___________ Telephone #: ________________________________

Reason for MRI and/or symptoms: _______________________________________________________________________
____________________________________________________________________________________________________

1) Have you had any prior surgery or an operation: Yes / No. If yes, please indicate date and type of surgery/operation.
____________________________________________________________________________________________________
____________________________________________________________________________________________________
____________________________________________________________________________________________________

2) Have you had a prior diagnostic imaging study or examination (MRI, CT, Ultrasound, X-ray, etc.)? Yes / No.
If yes, please list:

<table>
<thead>
<tr>
<th>Body Part</th>
<th>Date</th>
<th>Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRI</td>
<td></td>
<td></td>
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<tr>
<td>CAT Scan</td>
<td></td>
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<tr>
<td>X-Ray</td>
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<tr>
<td>Ultrasound</td>
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<tr>
<td>Nuclear Medicine</td>
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<tr>
<td>Other</td>
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</tbody>
</table>

3) Have you experienced any problems related to a previous MRI examination or MR Procedure? YES / NO

4) Have you had an injury to the eye involving a metallic object or fragment (e.g., metallic slivers, shavings, foreign body, etc.)? YES / NO. If yes, please explain:

5) Have you ever been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel, etc.)? YES / NO. If so, please explain:

6) Do you have a history of asthma, allergic reaction, respiratory disease, or reaction to a contrast medium or dye used for an MRI, CT, or X-ray examination? YES / NO.

7) Do you have anemia or any disease(s) that affects your blood, a history of renal (kidney) disease, renal (kidney) transplant, high blood pressure(hypertension), liver(hepatic) disease, a history of diabetes, or seizures? YES / NO. If so, please describe:
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

For Female Patients:

8) Date of last menstrual period: _____/_____/_______ Post-menopausal? YES / NO

9) Are you pregnant or experiencing a late menstrual period? YES / NO

10) Are you taking any type of fertility medication or having fertility treatments? YES / NO

11) Are you currently breastfeeding? YES / NO

MRI systems use strong magnetic fields & radio-frequency energy for imaging the body. Certain implants, devices, objects, and even clothes may pose a hazard to individuals in close proximity to the MRI system and/or interfere with the MRI procedure. The MRI system is always on.

Turn over & complete.
MRI Procedure Screening Questionnaire Continued...

Date: _____/_____/______  MRN: _______________________

Please indicate if you have any of the following:
☐ Yes  ☐ No Aneurysm clip(s)
☐ Yes  ☐ No Cardiac pacemaker
☐ Yes  ☐ No Implanted cardioverter defibrillator (ICD)
☐ Yes  ☐ No Electronic implant or device
☐ Yes  ☐ No Magnetically-activated implant or device
☐ Yes  ☐ No Neurostimulation system
☐ Yes  ☐ No Spinal cord stimulator
☐ Yes  ☐ No Internal/external electrodes or wires
☐ Yes  ☐ No Bone growth/bone fusion stimulator
☐ Yes  ☐ No Cochlear, otologic, or other ear implant
☐ Yes  ☐ No Insulin or other infusion pump
☐ Yes  ☐ No Implanted drug infusion device
☐ Yes  ☐ No Any type of prosthesis (eye, penile, etc.)
☐ Yes  ☐ No Heart valve prosthesis
☐ Yes  ☐ No Eyelid spring or wire
☐ Yes  ☐ No Artificial or prosthetic limb
☐ Yes  ☐ No Metallic stent, filter, or coil
☐ Yes  ☐ No Vascular access port and/or catheter
☐ Yes  ☐ No Radiation seeds or implants
☐ Yes  ☐ No Swan-Ganz or thermodilution catheter
☐ Yes  ☐ No Medication patch (Nicotine, Nitroglycerine)
☐ Yes  ☐ No Wire mesh implant
☐ Yes  ☐ No Tissue expander (e.g., breast)
☐ Yes  ☐ No Surgical staples, clips, or metallic sutures
☐ Yes  ☐ No Joint replacement (hip, knee, etc.)
☐ Yes  ☐ No Bone/joint pin, screw, nail, wire, plate, etc.
☐ Yes  ☐ No IUD, diaphragm, or pessary
☐ Yes  ☐ No Are you here for an MRI examination?
☐ Yes  ☐ No Dentures or partial plates
☐ Yes  ☐ No Tattoo or permanent makeup
☐ Yes  ☐ No Body piercing jewelry
☐ Yes  ☐ No Hearing aid (Remove before entering MR system room)
☐ Yes  ☐ No Other implant _______________________
☐ Yes  ☐ No Breathing problem or motion disorder

Please mark on the figures below the location of any implants or metal inside of or on your body.

Instructions for the Patient:
1. Remove ALL jewelry and ALL body piercing jewelry and ALL hair/eye lash accessories.
2. Remove dentures, false teeth, partial dental plates, retainers.
3. Remove hearing aids and eyeglasses.
4. Remove ALL clothing (to include undergarments) and change into a hospital gown.
5. Please use the restroom before your MRI exam.
6. Please make sure that you receive a pair of earplugs and/or the headphones before your MRI exam begins. Some patients may find the noise levels unacceptable, and the noise levels may affect your hearing.

I attest that the above information is correct to the best of my knowledge. I read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and regarding the MR procedure that I am about to undergo.

__________________________________                    _____/_____/________                          __________
__________________________________                    _____/_____/________                          __________

Patient/Parent/Guardian/RN/MD/Other Signature  Patient/Parent/Guardian/RN/MD/Other Print
__________________________________                    _____/_____/________                          __________

Level 2 MRI Personnel Signature