

NAME: _____ Current height: _____ Current weight: _____

- Do you have a Cardiac Pacemaker, ICD, Bladder Pacemaker or Pacemaker leads? Yes No
- If you have a Pacemaker is it MRI conditional? Yes No
- Do you have a Cochlear Ear Implant or any type of ear implant? Yes No
- Dental Implant held in place by a Magnet? Yes No
- Swan-Ganz Thermodilution catheter? Yes No

Please contact the MRI department prior to continuing if you answer yes to any of the above questions.

MRI department must be contacted if you answer yes to any of the following as more information may be needed to determine compatibility and patient safety.

- Are you claustrophobic? Yes No
- Do you have an Implanted Stimulator Device? Yes No
- Do you have an Implanted Drug Infusion Device? Yes No
- Do you have an Insulin pump? Yes No
- Do you have a Vascular/Cardiac stent, access port or catheter? Yes No
- Do you have Aneurysm clips, Hemostatic or Vascular clips? Yes No
- Do you have a Ventricular Shunt? Yes No
- Do you have a heart valve repair or replacement? Yes No
- Do you have an IVC filter or wire mesh implant? Yes No
- Are you wearing any Transdermal Drug Patches? Yes No
- Do you have an Eye implant? Yes No
- Do you have a Penile implant? Yes No

Please answer Yes or No to all Questions.

- Do you have any type of prosthesis or joint replacement? Yes No
- Have you had to swallow a Pillcam for endoscopy/colonoscopy? Yes No
- Do you have any gastrointestinal clips? Yes No
- Have you ever done metal welding, cutting, grinding, etc..? Yes No
- Have you ever had metal in your eyes? Yes No
- Do you wear a hearing aid? Yes No
- Do you have shrapnel, bullets, BB's or any other foreign metal in your body? Yes No
- Do you have any body piercings? Yes No
- Do you wear dentures or partial plates? Yes No
- Do you have any magnets in or on your body? Yes No
- Do you have permanent makeup or tattoos? Yes No
- Have you ever had cancer? Yes No
- If yes, what kind?
- Women Only... Do you have an IUD? Yes No
- Are you pregnant? Yes No



Have you had an operation on **the part of the body we are examining?**..... Yes No

Have you ever injured the part of **the body we are examining?** Yes No
If yes, when and how? _____

Have you had **this part of your body** examined in **radiology** before?..... Yes No

If yes, what? X-ray MRI CAT Scan Ultrasound

Where? _____ Date of most recent X-ray, MRI, Cat Scan or Ultrasound _____

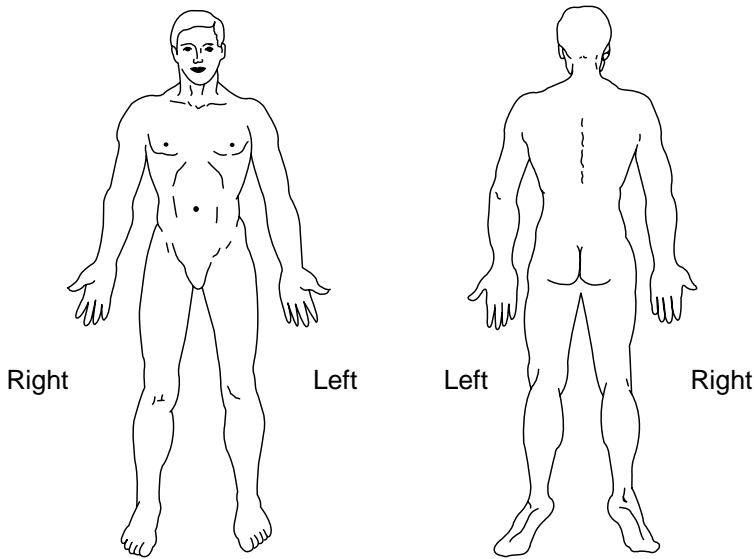
Have you had organs removed? Yes No

If yes, please check all that apply:

- Ovaries Kidney Bladder Pancreas Gall bladder
- Appendix Part of colon All of colon Part of small bowel
- Uterus Part of lung Other (please specify) _____

Please indicate on the diagrams where your symptoms are

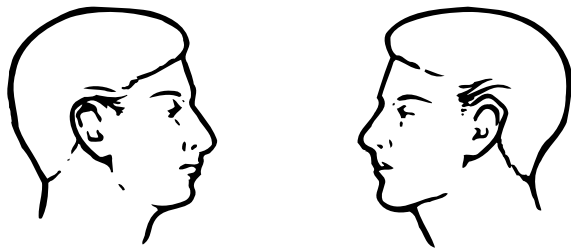
- Pain (P)
- Numbness (N)
- Tingling (T)
- Weakness (W)



Specify: Pain (P), Numbness (N), Stiffness (S)

Please indicate if you have any of the following:

- Headaches Yes No
- Weakness Yes No
- Speech Problems Yes No
- Difficulty thinking Yes No
- Seizures Yes No
- Numbness Yes No
- Difficulty Walking Yes No
- Balance Problems Yes No
- Hearing Problems Yes No
- Visual Problems Yes No



Right

Left

I agree that the above questions have been answered to the best of my knowledge.

Patient Signature: _____

Date: _____

Time: _____



Patient Information/Label



MRI Screening