



MRI SCREENING FORM

Patient Name: _____

Please notify the staff immediately if you have medication to take prior to your MRI.

For safety and imaging purposes, we need to know if you have any of the following:

- Yes No Cardiac pacemaker/Heart valve/Heart surgery: **Date/type**_____
- Yes No Shunts/ Stents/ Intravascular coil: **Date/type**_____
- Yes No Ear or eye implants / surgery: **Date/type**_____
- Yes No Injury to eye involving metal or metal shavings_____
- Yes No Are you or do you suspect pregnancy? Or are you breast-feeding?
- Yes No Brain or brain aneurysm surgery:**Date/type**_____
- Yes No Any electrical, mechanical, magnetic implants, or body piercings:
Date/type_____
- Yes No Schrapnel or metal fragments in skin or body: **Specify**_____
- Yes No **All** other surgeries: **Date/type**_____
- _____
- _____
- Yes No Dentures/ Hearing aid / Wig: **Please circle which applies.**
- Yes No IUD or penile prosthesis: **Date/type**_____
- Yes No Tattoo eyeliner
- Yes No History of cancer or tumors:_____
- Yes No Radiation therapy/ Chemotherapy;_____
- Yes No Allergies: **Specify**_____
- Yes No Kidney, respiratory, liver, or blood disorders: **Specify**_____
- Yes No Transdermal patches (hormone replacement, smoking cessation or medication patches)

Patient or guardian Signature _____ Date _____
Patient unable to sign due to: _____ Witness _____ Date _____
