

UNIVERSITY DIAGNOSTIC INSTITUTE

MRI SCREENING QUESTIONNAIRE

Date _____ Date of Birth _____

Name _____

Sex _____ Age _____ Weight _____

Please list all surgeries _____

List allergies _____

Specifically, do you have any metal or implanted items in your body from surgeries or injuries (especially eyes)?

Please answer to the following:

YES	NO	
_____	_____	Pregnant (Date of LMP: _____)
_____	_____	Aneurysm clips
_____	_____	Cardiac pacemaker
_____	_____	Pacemaker wires or internal electrodes
_____	_____	Cardiac stents
_____	_____	Artificial heart valves
_____	_____	Cardiac defibrillator, biostimulator or neurostimulator systems (VSN)
_____	_____	Intravascular coils, filters or stents
_____	_____	Implanted pumps (including pain, insulin or chemo)
_____	_____	Cerebrospinal Fluid (CSF) shunt valves
_____	_____	Implanted orthopedic devices (pins, rods, screws, plates, wires, artificial limbs or joints)
_____	_____	Surgical clips, staples or wires
_____	_____	Vascular access port
_____	_____	Cochlear implant (ear), baha implant (ear), or ocular implant (eye)
_____	_____	Hearing aids
_____	_____	Tattoos or permanent make-up such as tattooed eyeliner
_____	_____	Dentures, dental implants, braces or permanent retainers
_____	_____	Any other implanted electronic, mechanical or magnetic implant or item
_____	_____	Undergone any GI studies that have required you to swallow a pill cam capsule
_____	_____	Celsius control system
_____	_____	Transdermal medication patches or any other drug delivery patches
_____	_____	IUD, bladder sling, or bladder control systems
_____	_____	Penile implant or prostate seeds

Are you on dialysis? _____

Are you being treated for chronic kidney disease? _____

Are you diabetic? _____

Do you have a history of kidney disease, kidney cancer or kidney transplant? _____

I attest that the above information is correct and accurate to the best of my knowledge. I have read and understand the entire contents of this form and I have had the opportunity to ask questions regarding the information on this form.

Patient's Signature _____ Date _____
 If minor, guardian signature

MD or RT Signature _____ Date _____

**** PLEASE REMOVE ALL JEWELRY BEFORE YOUR EXAM ****