

# MRI Patient Screening Form

Patient Name \_\_\_\_\_ Date \_\_\_\_\_ Sex: M F Weight \_\_\_\_\_

DOB: \_\_\_/\_\_\_/\_\_\_ Type of MR \_\_\_\_\_ Appointment Date/Time: \_\_\_\_\_

Please list all surgeries and date:

_____	_____
_____	_____
_____	_____
_____	_____

1. Have you worked as a machinist, metal worker, or welder using iron or steel? Yes No
2. Have you ever had metal in your eyes or removed from you eyes? Yes No
  - 2a. If yes, please explain: \_\_\_\_\_
3. Are you pregnant? Yes No
  - 3a. If yes, are you a nursing mother? Yes No
4. Are you claustrophobic? Yes No
5. Do you have any allergies? Yes No \_\_\_\_\_
6. Are you taking any medication? Yes No
  - 6a. If yes, please list? \_\_\_\_\_

**Please check the appropriate box if you have the following items:**

Yes	No		Yes	No	
—	—	Pacemaker or Pacemaker Wires	—	—	Penile Implant
—	—	Aneurysm Clips	—	—	Joint Replacements (Prosthesis)
—	—	Heart Stents	—	—	Body Piercing Jewelry
—	—	Infusion Pump	—	—	Cochlear Implants (ear)
—	—	Defibrillator	—	—	Ocular Implants (eyes)
—	—	Insulin Pump	—	—	Shrapnel, grenade, mortar, or b.b.
—	—	Medicine Patch	—	—	Wire Sutures
—	—	Neurostimulators (Tens-unit)	—	—	Dentures/Braces
—	—	Electrodes	—	—	Embolization Coil
—	—	Hearing Aids	—	—	Aortic Clips
—	—	IUD	—	—	Tattoos
—	—	Shunts, Spinal or Ventricular	—	—	Other Implants _____

**Please do no enter the MRI room with any of the following:  
Watch, wallet, hearing aides, hairpins, pocket knife, keys, coins, beepers, cell phones, credit cards.**

Patient/Parent/Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Technologist Signature: \_\_\_\_\_ Date: \_\_\_\_\_