**MRI SAFETY SCREENING QUESTIONNAIRE**

## *Newport Diagnostic Center*

|  |  |  |
| --- | --- | --- |
| Name: | Date of Birth: | MRN: |
| Today’s Date: | Height:   | Weight: |

 

Magnetic resonance imaging (MRI) systems use strong magnetic fields and radio-frequency energy for imaging soft tissue in the body. Certain implants, devices, or objects may pose a hazard to individuals in close proximity to the magnet of the MRI system and/or may interfere with the MRI procedure.

|  |  |  |
| --- | --- | --- |
| What body part is being examined today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| What medical imaging tests and/or treatments have you had for this problem? (Prior MRI, injections, etc.) |  |  |
|  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Where \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| Have you had surgery in the body part that is being scanned today? [ ]  Yes [ ]  No  |  |  |
|  If yes, when (approximate date)? \_\_\_\_\_\_\_\_\_\_\_\_ Procedure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| Please describe your symptoms: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| Do you have a personal history of Cancer? [ ]  Yes [ ]  No  |  |  |
|  If yes, please indicate the type of cancer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |

 **Please shade in the areas below in the figures where you are experiencing your pain/symptoms.**



 **Front Back**

**Please continue on page 2**

**MRI SAFETY SCREENING QUESTIONNAIRE, continued** \*\*\*\* **Please provide any Implant Card you have.**

Do you have you any of the following implants?

|  |  |  |
| --- | --- | --- |
| YES | NO |  |
|[ ] [ ]  Cardiac pacemaker or implanted cardioverter defibrillator/ICD (in place or removed) |
|[ ] [ ]  Aneurysm Clips or Coils |
|[ ] [ ]  Cardiac monitor / Loop recorder |
|[ ] [ ]  Internal electrodes or wires *(pacing wires, DBS or VNS wires)* |
|[ ] [ ]  Shunt (do you know the name and make of your shunt? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|[ ] [ ]  Neurostimulator |
|[ ] [ ]  Bone Growth Stimulator |
|[ ] [ ]  Implanted drug pump *(ex; for chemotherapy/other pain medicine)* |
|[ ] [ ]  Stents If yes, Where in your body? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|[ ] [ ]  Heart Valve |
|[ ] [ ]  Filters / Electronic devices |
|[ ] [ ]  Pumps, coil, filter |
|[ ] [ ]  Ear (Cochlear) implant, middle ear implant |
|[ ] [ ]  Tissue expander |
|[ ] [ ]  Magnetic eyelashes |
|[ ] [ ]  External drug pump / or monitor *(for Insulin or other medicine)* |
|[ ] [ ]  Hearing aids (Must be removed prior to entering the MRI suite) |
|[ ] [ ]  IUD If yes, what Brand / type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|[ ] [ ]  Body Piercing (you may be asked to remove all jewelry) |
|[ ] [ ]  Have you EVER had metal in your eyes? If yes, was it removed? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Implanted post-surgical hardware (pins, rods, screws, plates, wires)? [ ]  Yes [ ]  No

 If yes, what and where in your body? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any other implanted devices in your body not listed above? [ ]  Yes [ ]  No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you pregnant or could you possibly be pregnant? [ ]  Yes [ ]  No Are you breast-feeding? [ ]  Yes [ ]  No

 If you are still menstruating, please provide the date of your last period \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a history of?

 YES NO YES NO

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| [ ]  | [ ]  | Kidney disease | [ ]  | [ ]  | Are you on Dialysis |
| [ ]  | [ ]  | Diabetes | [ ]  | [ ]  | Allergic reaction to MRI contrast |
| [ ]  | [ ]  | Drug Allergy, type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |

I attest the above information is correct 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/Parent/Guardian/other Signature Date