PLEASANTON
DIAGNOSTIC IMAGING CENTER

# *MRI Screening Questionnaire*

Patient Name: _____ Date:_____

Sex: _____ DOB: _____ Weight: _____ Height: _____

This questionnaire is designed to assist us in determining if it is safe for you to undergo a magnetic resonance imaging procedure. It is important that you answer all of the following questions. **If you don't understand any question, please ask for assistance.**

1. Do you have a cardiac pacemaker, implantable cardio defibrillator, stents, or cardiac wires? Yes o No o Don't Know o
2. Do you have cochlear implants in your inner ear? Yes o No o Don't Know o
3. Do you have a history of kidney disease or currently on kidney dialysis? Yes o No o Don't Know o
4. Have you ever had any head surgery requiring aneurysm clips? Yes o No o Don't Know o
5. Have you ever had any type of surgery? Yes o No o Don't Know o
   If yes, please list: _____
6. Do you have any surgically implanted metal of any type in your body? Yes o No o Don't Know o
   If yes, please list: _____
7. Do you have any metal pins, prosthesis or metallic object in, or attached to, your body? Yes o No o Don't Know o
   If yes, please list: _____
8. Have you ever been exposed to metal fragments that could be lodged in your eyes or body? Yes o No o Don't Know o
9. Do you have a hearing aid, middle/inner ear prosthesis or dentures? Yes o No o Don't Know o
10. Do you have any type of electronic device (stimulator or pump) implanted in your body? Yes o No o Don't Know o
11. Do you have or have you ever had tattoos, tattooed eyeliner, lipliner or body piercing? Yes o No o Don't Know o
12. Do you wear a medicine skin patch on your body (e.g., nitroglycerin, nicotine, or hormone)? Yes o No o Don't Know o
13. Have you ever had a reaction to a contrast agent used for MRI, CT or X-ray? Yes o No o Don't Know o
14. Do you have a history of panic attacks or a fear of enclosed or narrow places? Yes o No o Don't Know o
15. If you are a woman – are you pregnant, or is it possible that you might be pregnant? Yes o No o Don't Know o
16. If you are a woman – are you breastfeeding? Yes o No o
17. Is there any other item or device you believe we should know about prior to performing the procedure, if yes, please describe

_____

I certify that I have read and understood the questions asked in this questionnaire and that the above responses are correct to the best of my knowledge. I understand that it is my responsibility to inform the Center of any metal fragments and/or devices that may be in my body and that by failing to do so may cause serious bodily injury or be life threatening. I agree that should I have any metal in my body and, after consultation with a physician, elect to proceed with the MRI, I agree to release Center from any and all liability for any injury.

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| Patient or Legal Representative Signature | Print Name and Authority (if legal representative) | Date |
| Witness or Interpreter Signature | Print Name | Date |
| Physician/Registered Nurse/Technologist | Print Name and Title | Date |