

# 31 NORTH IMAGING GROUP --- MRI SCREENING FORM

Please answer the following. If you have any questions, ask the technologist. A physician is also available if needed.

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

DOB: \_\_\_\_\_ HT: \_\_\_\_\_ WT: \_\_\_\_\_

PART TO BE SCANNED: \_\_\_\_\_

REASON FOR MRI: \_\_\_\_\_

YES NO 1. Have you ever had an MRI?  
Body Part \_\_\_\_\_ When/Where \_\_\_\_\_

YES NO 2. Have you ever worked with metal (grinding, fabricating, etc.) or ever had an injury to the eye involving a metallic object (i.e. metallic slivers, shavings, or foreign body)? If so please describe below:  
\_\_\_\_\_

YES NO 3. (Females) Are you pregnant or is there any chance of pregnancy?

YES NO 4. (Females) Date of last menstrual period? \_\_\_\_\_

YES NO 5. (Females) Are you breastfeeding?

YES NO 6. Are you claustrophobic?

YES NO 7. Have you ever had any surgeries? Please list and date \_\_\_\_\_

YES NO 8. Any history of cancer?  
When: \_\_\_\_\_ Type: \_\_\_\_\_ Treatment: \_\_\_\_\_

**Some of the following items may be hazardous to your safety and some can interfere with the MRI exam:  
Please circle the correct answer to each of the following. Do you have any of the following?**

YES	NO	Pacemaker or Pacemaker wires	YES	NO	Spinal Cord Stimulator
YES	NO	Brain Aneurysm Clip	YES	NO	Breast Implants
YES	NO	Implanted Cardiac Defibrillator	YES	NO	Transdermal Patch
YES	NO	Carotid Artery Vascular Clamp	YES	NO	Tattooed Makeup
YES	NO	Electronic Implant or Device	YES	NO	Retinal Tac Implant
YES	NO	Neurostimulator	YES	NO	Body Piercing(s)
YES	NO	Insulin or Infusion Pump	YES	NO	Metal Fragments (bullets, shrapnel, BBs)
YES	NO	Implanted Drug Infusion System	YES	NO	Swan-Ganz Catheter
YES	NO	Bone Growth/Fusion Simulator	YES	NO	Cochlear, Otologic or Ear Implant
YES	NO	Any type of Prosthesis (eye, penile, etc.)	YES	NO	Metal or Wire Mesh Implants
YES	NO	Wire Sutures or Surgical Implants	YES	NO	Aortic Clip
YES	NO	Heart Valve Prostheses	YES	NO	Harrington Rods (spine)
YES	NO	Artificial Limb or Joint Replacement	YES	NO	Metal Rods in Bones
YES	NO	Intravascular Stent, Filters or Coils	YES	NO	Bone/Joint Pin, Screw, or Plate
YES	NO	Hearing Aid (Remove before MRI)	YES	NO	Breast Tissue Expander
YES	NO	Shunt (spinal or intraventricular)	YES	NO	Other Implant _____
YES	NO	Vascular Access Port and or Catheter	YES	NO	IUD Intrauterine Device

**I ATTEST THAT 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 Signature \_\_\_\_\_ Date \_\_\_\_\_

MRI Technologist Signature \_\_\_\_\_ Date \_\_\_\_\_