UNIVERSITY RADIOLOGY
Leaders in Subspecialty Imaging

MRI Screening Questionnaire

Date _____ / _____ / _____ Name _____ DOB _____ ☐ Male ☐ Female

LAST FIRST MIDDLE INITIAL

1. Have you had prior surgery or an operation (e.g. arthroscopy, endoscopy, etc.) of any kind? ☐ No ☐ Yes
   If yes, please indicate the date and type of surgery
   Date _____ / _____ / _____ Type of surgery _____
   Date _____ / _____ / _____ Type of surgery _____
   Date _____ / _____ / _____ Type of surgery _____
   Date _____ / _____ / _____ Type of surgery _____
2. Have you experienced any problem related to a previous MRI examination or MR procedure? ☐ No ☐ Yes
   If yes, please describe: _____
3. a. Have you had an injury to the eye involving a metallic object or fragment ☐ No ☐ Yes
   (e.g. metallic slivers, shavings, foreign body, etc.)?
   b. Has any other body part had a penetrating injury by a metallic object or foreign body ☐ No ☐ Yes
   (e.g. bullet, BB, shrapnel, etc.)?
   If yes to a or b, please describe: _____
4. Have you had a colonoscopy or upper endoscopy ("EGD") within the past 3 months? ☐ No ☐ Yes
   If yes, were any clips placed? ☐ No ☐ Yes ☐ Don't know

Please indicate if you have any of the following:

☐ Yes	☐ No	Aneurysm clip(s)	☐ Yes	☐ No	Vascular access port and/or catheter
☐ Yes	☐ No	Pacemaker or defibrillator (ICD)	☐ Yes	☐ No	Radiation seeds or implants
☐ Yes	☐ No	Any metallic fragment or foreign body	☐ Yes	☐ No	Swan-Ganz or thermodilution catheter
☐ Yes	☐ No	Electronic implant or device	☐ Yes	☐ No	Medication patch (nicotine, nitroglycerine, etc.)
☐ Yes	☐ No	Joint replacement (hip, knee, etc.)	☐ Yes	☐ No	Wire mesh implant
☐ Yes	☐ No	Neurostimulator device	☐ Yes	☐ No	Tissue expander (e.g. breast)
☐ Yes	☐ No	Internal electrodes or wires	☐ Yes	☐ No	Surgical staples, clips, or metallic sutures
☐ Yes	☐ No	Bone growth / bone fusion stimulator	☐ Yes	☐ No	Bone / joint pin, screw, nail, wire, plate, etc.
☐ Yes	☐ No	Cochlear, otologic, or other ear implant	☐ Yes	☐ No	IUD, diaphragm, or pessary
☐ Yes	☐ No	Implanted drug infusion (e.g. insulin, pain meds)	☐ Yes	☐ No	Dentures or partial plates
☐ Yes	☐ No	Any type of prosthesis (eye, penile, etc.)	☐ Yes	☐ No	Tattoo or permanent makeup
☐ Yes	☐ No	Heart valve prosthesis	☐ Yes	☐ No	Body piercing jewelry
☐ Yes	☐ No	Eyelid spring or wire	☐ Yes	☐ No	Hearing aid
☐ Yes	☐ No	Artificial or prosthetic limb	☐ Yes	☐ No	Breathing problem or motion disorder
☐ Yes	☐ No	Metallic stent, filter, or coil	☐ Yes	☐ No	Claustrophobia
☐ Yes	☐ No	Shunt (spinal or intraventricular)	☐ Yes	☐ No	Other implant _____

IMPORTANT INSTRUCTIONS: Please remove all metallic objects before entering the MRI room. This includes: hearing aids, beepers, cell phones, keys, eyeglasses, hair pins, barrettes, jewelry, ear/body piercings, watches, safety pins, paperclips, money clips, magnetic strip cards (credit cards, etc.), coins, pens, pocket knives, nail clippers, steel-toed shoes, and tools.

WARNING: The MRI magnet is ALWAYS ON. Certain implants, devices, and other objects can be hazardous to you or interfere with the MRI study. DO NOT ENTER the MRI scanner room or MRI environment if you have any questions or concerns – instead, consult the MRI Technologist.

I attest that the above information is correct to the best of my knowledge. I have read and I understand the contents of this form, and have had the opportunity to ask questions about it and about the MR exam that I am about to undergo.

Signature of person completing form: _____ Date _____ / _____ / _____

Form completed by: ☐ Patient ☐ Relative ☐ Nurse _____

MRI Technologist _____ _____
PRINT NAME SIGNATURE

Level I or II staff _____ _____
PRINT NAME SIGNATURE