TRI-CITY RADIOLOGY

MRI SCREENING QUESTIONNAIRE

If you have medication to take prior to the MRI, please notify office staff now. Thank you.
The following items can interfere with the MRI imaging and some may be hazardous to your safety. Please complete thoroughly.

NAME ____ Height __________Weight ____________
PLEASE PRINT

YES	NO	
_____	_____	Cardiac pacemaker?
_____	_____	Neurostimulator (TENS Unit) or Electrode Implant?
_____	_____	Coronary Artery Bypass or Heart Valve Surgery? -- please specify below
_____	_____	Do you have Heart Stents? **If yes, please provide us with a copy of your stent card.**
_____	_____	Have you ever had brain surgery or brain aneurysm surgery?
_____	_____	Have you ever had ear surgery? If YES, what type ______________________________________
_____	_____	Do you have a shunt? If YES, SPINAL ____________ or VENTRICULAR ____________
_____	_____	Do you have any removable dental work?
_____	_____	Do you have any metal implants? If YES, where ____
_____	_____	Do you have an INSULIN PUMP, HEARING AID, or IUD? If YES, please **circle**
_____	_____	Have you ever had an incident of metal fragments in your eyes?
_____	_____	Have you ever had metal fragments or shrapnel in the **head** or **skin**? If YES, please **circle**
_____	_____	Metal plates, pins, screws, nails, clips, mesh implants, filters, or catheters? If YES, please **circle**
_____	_____	Do you have tattoo eyeliner?
_____	_____	Do you have Seizures or Epilepsy?
_____	_____	Are you pregnant or suspect pregnancy?
_____	_____	Are you breast feeding?
_____	_____	Have you had ANY SURGICAL PROCEDURES? If YES, list below with date.
_____	_____	HAVE ANY OF YOUR SURGERIES BEEN PERFORMED IN THE LAST 6 WEEKS?
_____	_____	Do you have any **ALLERGIES** or **REACTIONS** to drugs or substances? If YES, specify below.

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All medical procedures carry an element of risk and this procedure is no exception. The use of contrast media may provide more information to evaluate your problems and improve the quality of your exam. The most common adverse experience noted by patients receiving contrast is headache and nausea. Additional adverse events occur in less than 1% of patients. Your physician has considered the aforementioned risks before recommending this exam and he/she believes the diagnostic benefits outweigh the minimal risks involved.

I have read the above and give my consent to the performance of the MRI scan(s) ordered, including administration of contrast material, if indicated.

____
Signature of patient or guardian Date/Time

Person completing form: ____

____
Witness Date/Time