



MRI Patient Screening Questionnaire

Please fill out this screening form as soon as possible. If the answer is yes to any of the items listed below, call the Radiology Department at (650) 853-2956. Bring this completed form with you to your MRI appointment.

1. Please check the appropriate box for each of the following items.

- | YES | NO | | YES | NO | |
|--------------------------|--------------------------|---|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Cardiac pacemaker | <input type="checkbox"/> | <input type="checkbox"/> | Insulin pump |
| <input type="checkbox"/> | <input type="checkbox"/> | Internal pacing wires | <input type="checkbox"/> | <input type="checkbox"/> | Shrapnel/metal fragments: head, eyes, ears or skin |
| <input type="checkbox"/> | <input type="checkbox"/> | Vascular clips | <input type="checkbox"/> | <input type="checkbox"/> | Any metal implants |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart valve surgery | <input type="checkbox"/> | <input type="checkbox"/> | Wire sutures |
| <input type="checkbox"/> | <input type="checkbox"/> | Brain surgery | <input type="checkbox"/> | <input type="checkbox"/> | Pregnant |
| <input type="checkbox"/> | <input type="checkbox"/> | Aneurysm clips | <input type="checkbox"/> | <input type="checkbox"/> | IUD |
| <input type="checkbox"/> | <input type="checkbox"/> | Cochlear implant | <input type="checkbox"/> | <input type="checkbox"/> | Claustrophobia |
| <input type="checkbox"/> | <input type="checkbox"/> | Bone Growth Stimulator/
Neurostimulator (Tens unit) | <input type="checkbox"/> | <input type="checkbox"/> | Body piercing |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergy to MRI contrast | <input type="checkbox"/> | <input type="checkbox"/> | Hearing aid |
| <input type="checkbox"/> | <input type="checkbox"/> | Currently breastfeeding | <input type="checkbox"/> | <input type="checkbox"/> | Transdermal patches |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney disease, renal insufficiency,
renal failure, renal transplant | <input type="checkbox"/> | <input type="checkbox"/> | Tattoo and/or permanent makeup |

2. Have you ever worked as a machinist or metal worker, or with any profession grinding metal? YES NO

3. Your current weight _____ (lbs)

Signature

Date