



DIAGNOSTIC IMAGING MRI SCREENING FORM

Please check the appropriate answer for each item listed.

If you answer YES to any implanted device, we have to know the manufacturer and when it was implanted. If surgical reports are required, your test may need to be rebooked.

	YES	NO
1. Have you ever had an MRI exam? When? Where? What body part?		
2. Are you claustrophobic (fear of confined spaces)?		
3. Are you taking any medication for this MRI?		
4. Have you had any heart surgery and/or a Pacemaker inserted?		
5. Do you have any brain surgery and/or aneurysm clips ? What? When?		
6. Have you had surgery related to the body part being examined today?		
7. Do you have an epidural catheter implanted? What? When?		
8. Do you have any ear or eye implants ? Manufacturer? When?		
9. Do you have any medication pumps of any kind?		
10. Do you have a neurostimulator or a TENS device? Manufacturer? When?		
11. Have you had a limb or joint replacement/pins/rods/screws?		
12. Have you ever had metal removed from your eyes, head, or body?		
13. Do you do any metal work? (mechanic, welder, machinist)		
14. Do you have any Tattoos or body piercing?		
15. Do you have an intrauterine device or penile implant? Manufacturer? When?		
16. Do you wear any medication patches?		
17. Do you have breast implants? What kind?		
18 Do you have ANY implants? What kind?		
19 Have you undergone a colonoscopy/endoscopy in the past 6 weeks? If yes, obtain report to ensure no clips in place. If no, proceed with booking		
20 Do you have any shunts, stents, or surgical clips in your body?		
21 Any possibility of pregnancy?		
22 Are you breast feeding?		
23 Do you have any special needs?		
24 Do not wear any magnetic nail polish		
25 Due to limited space in our MRI waiting room, it is reserved for patients only		