



## MRI PATIENT HISTORY & SAFETY QUESTIONNAIRE

Date: \_\_\_\_\_ Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Sex: ☐ M ☐ F

Previous imaging of this area ☐ Yes ☐ No If yes, facility name: \_\_\_\_\_

Prior surgery on this area ☐ Yes ☐ No If yes, describe: \_\_\_\_\_

Date of injury (if applicable): \_\_\_\_\_

### SAFETY SCREENING (Please check all that apply)

#### CARDIAC & VASCULAR

- ☐ Pacemaker
- ☐ Implanted defibrillator
- ☐ Internal pacing wires
- ☐ Artificial heart valve
- ☐ Aneurysm clips
- ☐ Stents / filters / coils
- ☐ Swan-Ganz catheter

#### IMPLANTED DEVICES

- ☐ Neurostimulator
- ☐ Medication pump
- ☐ Spinal / ventricular shunt
- ☐ Bone growth stimulator
- ☐ Magnetic implant
- ☐ Electrodes

#### HEAD, EARS, EYES

- ☐ Cochlear / ear implant
- ☐ Hearing aids
- ☐ Eye implant
- ☐ Metal fragments in eyes
- ☐ Braces

#### ORTHOPEDIC / METAL EXPOSURE

- ☐ Artificial joint or limb
- ☐ Metal / wire mesh implant
- ☐ Shrapnel / metallic fragments

#### REPRODUCTIVE

- ☐ IUD / diaphragm
- ☐ Penile implant
- ☐ Pregnant or breastfeeding

#### EXTERNAL / REMOVABLE ITEMS

- ☐ Removable dental work
- ☐ Body piercings
- ☐ Tattoos
- ☐ Cosmetic tattoos
- ☐ Transdermal patch
- ☐ Glucose Monitor

#### MEDICAL HISTORY

- ☐ History of cancer
- ☐ Drug allergies

#### DESCRIPTION

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

#### CURRENT SYMPTOMS

Patient Signature: \_\_\_\_\_

#### FOR TECHNOLOGIST USE ONLY

TECH INITIALS: \_\_\_\_\_

Clinical History: \_\_\_\_\_

Exam(s): \_\_\_\_\_ DX: \_\_\_\_\_