



***MRI SCREENING SHEET***

PATIENT NAME: \_\_\_\_\_ ACCOUNT #: \_\_\_\_\_

DATE: \_\_\_\_\_ DOB: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

MRI BODY PART: \_\_\_\_\_

**Do you have any of the following?**

	<b>Yes</b>	<b>No</b>
1. Metal slivers or rust in your eyes	<input type="checkbox"/>	<input type="checkbox"/>
2. Brain aneurysm clips	<input type="checkbox"/>	<input type="checkbox"/>
3. Ear implants (example: cochlea, stapes)	<input type="checkbox"/>	<input type="checkbox"/>
4. Hearing aids	<input type="checkbox"/>	<input type="checkbox"/>
5. Aortic valve clips	<input type="checkbox"/>	<input type="checkbox"/>
6. Cardiac pacemaker or mechanical heart valve	<input type="checkbox"/>	<input type="checkbox"/>
7. IUD (What type?) _____	<input type="checkbox"/>	<input type="checkbox"/>
8. Penile implant (What type?) _____	<input type="checkbox"/>	<input type="checkbox"/>
9. Joint replacement	<input type="checkbox"/>	<input type="checkbox"/>
10. Metal rods, plates, screws, nails, or clips	<input type="checkbox"/>	<input type="checkbox"/>
11. Body piercing or tattoos	<input type="checkbox"/>	<input type="checkbox"/>
12. Allergies to any medications	<input type="checkbox"/>	<input type="checkbox"/>
13. Claustrophobia	<input type="checkbox"/>	<input type="checkbox"/>
14. Surgery in the past 6 weeks (What kind?) _____	<input type="checkbox"/>	<input type="checkbox"/>
15. Are you Pregnant? (Duration) _____	<input type="checkbox"/>	<input type="checkbox"/>
16. Have you ever had an MRI before (What kind?) _____ (When/Where?) _____	<input type="checkbox"/>	<input type="checkbox"/>