Magnetic Resonance Imaging Patient Questionnaire

Name:_____
Date of Birth:_____
Age: _____
Height: _____
Weight:_____

INDICATE IF YOU HAVE ANY OF THE FOLLOWING:

Have you ever had any surgery in the area being scanned	□Yes □No
Are you pregnant, possibly pregnant, or breastfeeding	□Yes □No
Cardiac Pacemaker, Wires, or Defibrillator: What kind? _____	□Yes □No
Brian aneurysm clip	□Yes □No
Hearing aid / Cochlear implant	□Yes □No
Electrical stimulator for nerves or bone	□Yes □No
Bullet /Shrapnel	□Yes □No
Magnetically activated implant or device	□Yes □No
Infusion pump	□Yes □No
Artificial limb or joint	□Yes □No
Artificial heart valve	□Yes □No
Shunt	□Yes □No
Surgical clips, staples, wires, mesh or sutures	□Yes □No
Orthopedic hardware (plates, screws, pins, rods, wires)	□Yes □No
Jewelry / Body piercing	□Yes □No
Medication patch	□Yes □No
Have you ever had an allergic reaction to gadolinium contrast material	□Yes □No

I attest that the above information is correct to the best of my knowledge. I have read and understand the entire contents of this form and have had the opportunity to ask questions.

Signature (Patient or guardian):_____ Date:_____