Advanced Imaging Center

MRI Safety Questionnaire

Patient Name: _____ Date: _____

Please answer the following questions. If you are unsure of the answer, leave it blank.

Do you have any of the following?	Circle Answer		
1. Claustrophobia	Yes	No	Not Sure
2. Cardiac Pacemaker/Defibrillator	Yes	No	Not Sure
3. Intracranial Bypass Graft Clips	Yes	No	Not Sure
4. Coronary Artery Bypass Clips	Yes	No	Not Sure
5. Aneurysm Clips	Yes	No	Not Sure
6. Renal Transplant Clips	Yes	No	Not Sure
7. Other Vascular Clips	Yes	No	Not Sure
8. Epilepsy	Yes	No	Not Sure
9. Middle Ear Prosthesis	Yes	No	Not Sure
10. Cardiac Valve Prosthesis	Yes	No	Not Sure
11. Orbital Prosthesis	Yes	No	Not Sure
12. Artificial Joint Prosthesis	Yes	No	Not Sure
13. Neurostimulator (Tens Unit)	Yes	No	Not Sure
14. Metal Mesh Implants	Yes	No	Not Sure
15. Dentures	Yes	No	Not Sure
16. Shrapnel	Yes	No	Not Sure
17. Harrington Rods	Yes	No	Not Sure
18. Metal Rods Or Pins	Yes	No	Not Sure
19. Intracranial/Brain surgery	Yes	No	Not Sure
20. Are you pregnant?	Yes	No	Not Sure
21. Have you had cataract surgery?	Yes	No	Not Sure
22. Have you ever worked with metal?	Yes	No	Not Sure
23. Have you ever had metal in your eye?	Yes	No	Not Sure
24. Have you had any previous surgeries?	Yes	No	Not Sure
25. Are you nursing?	Yes	No	Not Sure
26. Impaired Liver Function	Yes	No	Not Sure
27. Sickle Cell or other Blood Cell Diseases	Yes	No	Not Sure
28. Tattoo Eyeliner	Yes	No	Not Sure

Signature _____ Date _____

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