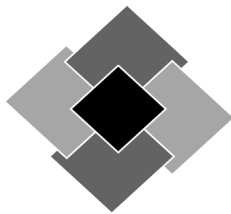


MRI Screening Questionnaire



**SUMMIT
MEDICAL
GROUP**

MRN# _____

DOB: _____

Patient Name: _____

Date: _____

Provider: _____

Name: _____ Gender: Female Male

DOB: ____/____/____ Age: _____ Weight: _____ lbs. Height: _____ (feet/inches)

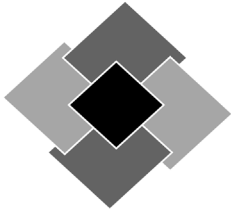
1. **Have you had any surgery, operation, or endoscopy, colonoscopy of any kind?** YES NO
If yes, indicate date and type of procedure: _____
2. **Do you, or have you ever had a pacemaker, implanted defibrillator, or aneurysm clips/coil?** YES NO
3. **Have you had a prior diagnostic imaging study or examination (MRI, CT, XRAY, Ultrasound)?** YES NO
 If yes, please list: _____
4. **Have you had an injury to the eye involving metallic objects or fragments?** YES NO
 If yes, please explain: _____
5. **Do you have a history of asthma, allergic reaction, respiratory disease, or reaction to a contrast medium or dye used for an MRI, CT, or XRAY?** YES NO
6. **Do you have anemia or any kidney disease(s) that affect your blood, a history of renal(kidney) disease, renal failure, kidney transplants, high blood pressure, liver disease, any history of diabetes?** YES NO
7. **Are you Claustrophobic?** YES NO
 If yes, are you taking medication for todays exam? YES NO
8. **Reason for todays exam:** _____

Female Patients Only:

1. Start date of last menstrual cycle: ____/____/____
2. Are you pregnant or think you may be pregnant? YES NO
3. Are you breastfeeding? YES NO
4. Are you taking any oral contraceptives or hormone replacement therapy (HRT)? YES NO
5. Are you taking any type of fertility medication or having fertility treatment? YES NO

Please indicate if you have any of the following:					
Aneurysm clip(s)	YES	NO	Surgical staples, clips, or metallic sutures	YES	NO
Cardiac pacemaker and/or Implanted	YES	NO	Joint replacement (hip, knee, etc.)	YES	NO

MRI Screening Questionnaire



**SUMMIT
MEDICAL
GROUP**

MRN#

DOB:

Patient Name:

Date:

Provider:

cardioverter defibrillator (ICD)					
Electric device or implant	YES	NO	IUD, diaphragm, or pessary	YES	NO
Neurostimulation system	YES	NO	Dentures or partial plates	YES	NO
Internal electrodes or wires	YES	NO	Tissue expander (i.e., breast)	YES	NO
Bone growth/bone fusion stimulator	YES	NO	Tattoo or permanent makeup	YES	NO
Cochlear, otologic, or other ear implants	YES	NO	Body piercing jewelry	YES	NO
Insulin or other infusion pump	YES	NO	Breathing problem or motion disorder	YES	NO
Any type of prosthesis (eye, penile, etc.)	YES	NO	Hearing aid (<i>MUST</i> be removed before entering MRI exam room)	YES	NO
Metallic stent, filter, or coil	YES	NO	Any clothing labeled 'anti-microbial, anti-bacterial, or anti-odor'?	YES	NO
Shunt (spinal or ventricular)	YES	NO	Any metallic fragment or foreign body?	YES	NO
Vascular access port and/or catheter	YES	NO	Other implant: _____	YES	NO
Transdermal (skin) Medication patch	YES	NO			

<p><u>WARNING:</u> Certain implants, devices or objects may be hazardous to you and or may interfere with the MR procedure (i.e., MRI, MR Angiography, MR Breast Biopsy). <u>DO NOT ENTER</u> the MRI room or MRI environment if you have any questions or concern regarding an implant, device, or object. Consult the MRI technologist, or Radiologist <u>BEFORE</u> entering MRI room. The MRI system magnet is <u>ALWAYS ON.</u></p>	<p>Technologist Note / Initials:</p>
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Please note: All patients are required to wear hearing protection (which we will provide) during their MRI exam. All patients are required to change into provided SMG apparel (gown, pant, etc.)

Signature	
<p><i>I understand and accurately answered all the safety questions on this form. I am also aware if I have taken medication to wither claustrophobia or pain in order to have my MRI, I cannot drive and must have someone drive me to and from the facility.</i></p>	
<p>_____</p> <p>Patient Signature (or person authorized to sign for Patient)</p>	<p>_____</p> <p>Date</p>
<p>_____</p> <p>Relationship to Patient if signing for Patient</p>	
<p>_____</p> <p>Interpreter Signature (or ID# if using service), as applicable</p>	<p>_____</p> <p>Date</p>