

**MRI METAL QUESTIONNAIRE**

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| **TO OUR PATIENTS AND ACCOMPANING FAMILY MEMBERS**  *The MR room contains a very strong magnet. Before you are allowed to enter, we must know if you have any metal in your body. Some metal objects can interfere with your scan or may even be dangerous, so PLEASE answer the following questions carefully. If you have a question regarding anything on this form, PLEASE DO NOT HESITATE TO ASK!* | | | | | | | | | | | | | | | | | |
| **THIS SECTION TO BE COMPLETED BY PATIENT** | | | | | | | | | | | | | | | | | |
| **NAME:** | | | | | | | **DOB:** | | | |  | | | **HEIGHT:** |  | **WEIGHT:** |  |
| Are you claustrophobic? | | | | | | Yes | | | | No | | | | | | | |
| Have you ever had surgery of any kind? | | | | | | Yes | | | | No | | | | | | | |
| If yes, please list them **ALL**: | | | | | | | | | | | | | | | | | |
| Have you ever been diagnosed with cancer? | | | | | | Yes | | | | No | | | | | | | |
| If yes, please explain: | | | | | | | | | | | | | | | | | |
| Are you pregnant or possibly pregnant? | | | | | | Yes | | | | No Date of last menstrual cycle: | | | | | | | |
| Have you had a metal injury to your eye? | | | | | | Yes | | | | No | | | | | | | |
| If Yes, was it removed from your eye? | | | | | | Yes | | | | No | | | | | | | |
| Have you had an MRI since the metal eye injury? | | | | | | Yes | | | | No If Yes, where: | | | | | | | |
| Have you ever had a previous allergic reaction to gadolinium, MRI contrast dye material? | | | | | | Yes | | | | No | | | | | | | |
| Do you have any other allergies to food, medicine, etc?  If yes, please explain: | | | | | | Yes | | | | No | | | | | | | |
| **Do you have any of the following:** | | | | | | | | | | | | | | | | | |
| Yes | No | Brain aneurysm clip | | Yes | | | | No | | | | Coil, filter, stent or shunt | | | | | |
| Yes | No | Eye implant or eyelid spring | | Yes | | | | No | | | | Any type of prosthesis (eye, ear, limb, penile) | | | | | |
| Yes | No | Ear implant (cochlear)/hearing aids | | Yes | | | | No | | | | Surgical clips, staples, wire, mesh or stitches | | | | | |
| Yes | No | Removable dental work | | Yes | | | | No | | | | Orthopedic plates, screws, pins, rods, or wires | | | | | |
| Yes | No | Cardiac pacemaker or defibrillator | | Yes | | | | No | | | | Bullets, BBs, pellets or metal shrapnel | | | | | |
| Yes | No | Artificial heart valve | | Yes | | | | No | | | | Intrauterine device (IUD) | | | | | |
| Yes | No | Vascular port or any implanted catheter | | Yes | | | | No | | | | Tattoo or body piercings  Location: | | | | | |
| Yes | No | Infusion pump or medication patch | | Yes | | | | No | | | | Any other implanted device  Location: | | | | | |
| Yes | No | Electrical stimulator for nerves/bone | |
| **Patient or Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | | **Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | |
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| **THIS SECTION IS TO BE COMPLETED BY MRI TECHNOLOGIST:** | | | | | | | | | | | | | | | | | |
| Why did the doctor order the MRI? | | | | | | | | | | | | | | | | | |
| How long has this been going on? | | | | | | | | | | | | | | | | | |
| Any recent accidents or injuries? | | | | | Yes | | | | No | | | | | | | | |
| If yes, please explain: | | | | | | | | | | | | | | | | | |
| Have you had any other tests of the same area? | | | X-Ray  US MRI CT Other: | | | | | | | | | | | | | | |
| If yes to one of the above, where/when? | | | | | | | | | | | | | | | | | |
| **MDI Technologist Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | | **Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | |

6/26/18