



**MRI SAFETY SCREENING & PATIENT HISTORY**

*PLEASE PRINT*

NAME \_\_\_\_\_ SEX \_\_\_\_\_ WEIGHT \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_

WHAT REASON OR SYMPTOMS LEAD YOU TO SEEK MEDICAL HELP?

\_\_\_\_\_  
\_\_\_\_\_

**If you have any of the following you CANNOT be exposed to the magnetic field of an MRI and are unable to have an MRI:**

- ~Cardiac Pacemaker                      ~Defibrillator  
~Bio or Neurostimulator              ~Cochlear Implants (ear)              ~Pregnancy

The following items can interfere with the Magnetic Resonance Imaging and some may be hazardous to your safety.

**CHECK YES OR NO FOR ANY OF THE FOLLOWING THAT APPLY.**

HAVE YOU EVER HAD ANY METAL IN YOUR EYES BY OPERATION OR ACCIDENT  YES  NO  
DO YOU HAVE A HISTORY OF METAL WORKING  YES  NO

**IF YOU ANSWER YES TO THE ABOVE PLEASE CONTACT OUR OFFICE AS FAR IN ADVANCE OF YOUR APPOINTMENT AS POSSIBLE, YOU WILL NEED TO ARRANGE TO HAVE YOUR EYES X-RAYED PRIOR TO YOUR APPOINTMENT.**

ARE YOU PREGNANT NOW	<input type="checkbox"/> YES <input type="checkbox"/> NO	ARTIFICIAL HEART VALVE	<input type="checkbox"/> YES <input type="checkbox"/> NO
BRAIN ANEURYSM CLIPS	<input type="checkbox"/> YES <input type="checkbox"/> NO	EVER DIAGNOSED WITH CANCER	<input type="checkbox"/> YES <input type="checkbox"/> NO
METALLIC IMPLANTS	<input type="checkbox"/> YES <input type="checkbox"/> NO	PERMANENT EYELINER	<input type="checkbox"/> YES <input type="checkbox"/> NO
SPINE OR BACK SURGERY	<input type="checkbox"/> YES <input type="checkbox"/> NO	SURGICAL CLIPS	<input type="checkbox"/> YES <input type="checkbox"/> NO

Have you had any other surgery? List date and type:

\_\_\_\_\_  
\_\_\_\_\_

**HAVE YOU HAD A PREVIOUS MRI?**  YES  NO – if yes **WHEN** \_\_\_\_\_

**WHERE** \_\_\_\_\_

**PLEASE SIGN BELOW AND SIGN BACK, INDICATING THAT YOU HAVE UNDERSTOOD AND ANSWERED ALL THE ABOVE QUESTIONS.**

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_

**PLEASE READ AND SIGN THE BACK OF THIS FORM.**

