INSIGHT IMAGING

MRI Screening Questionnaire

Patient Name:_____ Date:_____

Sex:_____ DOB:_____ Weight:_____ Height:_____

This questionnaire is designed to assist us in determining if it is safe for you to undergo a magnetic resonance imaging procedure. It is important that you answer all of the following questions. **If you don't understand any question, please ask for assistance.**

1. Do you have a cardiac pacemaker, implantable cardio defibrillator, stents, or cardiac wires? Yes ☐ No ☐ Don't Know ☐
2. Do you have cochlear implants in your inner ear? Yes ☐ No ☐ Don't Know ☐
3. Do you have a history of kidney disease or currently on kidney dialysis? Yes ☐ No ☐ Don't Know ☐
4. Have you ever had any head surgery requiring aneurysm clips? Yes ☐ No ☐ Don't Know ☐
5. Have you ever had any type of surgery? Yes ☐ No ☐ Don't Know ☐

   If yes, please list: _____
6. Do you have any surgically implanted metal of any type in your body? Yes ☐ No ☐ Don't Know ☐

   If yes, please list: _____
7. Do you have any metal pins, prosthesis or metallic object in, or attached to, your body? Yes ☐ No ☐ Don't Know ☐

   If yes, please list: _____
8. Have you ever been exposed to metal fragments that could be lodged in your eyes or body? Yes ☐ No ☐ Don't Know ☐
9. Do you have a hearing aid, middle/inner ear prosthesis or dentures? Yes ☐ No ☐ Don't Know ☐
10. Do you have any type of electronic device (stimulator or pump) implanted in your body? Yes ☐ No ☐ Don't Know ☐
11. Do you have or have you ever had tattoos, tattooed eyeliner, lipliner or body piercing? Yes ☐ No ☐ Don't Know ☐
12. Do you wear a medicine skin patch on your body (e.g., nitroglycerin, nicotine, or hormone)? Yes ☐ No ☐ Don't Know ☐
13. Have you ever had a reaction to a contrast agent used for MRI, CT or X-ray? Yes ☐ No ☐ Don't Know ☐
14. Do you have a history of panic attacks or a fear of enclosed or narrow places? Yes ☐ No ☐ Don't Know ☐
15. If you are a woman – are you pregnant, or is it possible that you might be pregnant? Yes ☐ No ☐ Don't Know ☐
16. If you are a woman – are you breastfeeding? Yes ☐ No ☐
17. Is there any other item or device you believe we should know about prior to performing the procedure – if yes, please describe:

    _____

I certify that I have read and understood the questions asked in this questionnaire and that the above responses are correct to the best of my knowledge. I understand that it is my responsibility to inform the Center of any metal fragments and/or devices that may be in my body and that by failing to do so may cause serious bodily injury or be life threatening. I agree that should I have any metal in my body and, after consultation with a physician, elect to proceed with the MRI, I agree to release Center from any and all liability for any injury.

Patient or Legal Representative Signature	Print Name and Authority (if legal representative)	Date
Witness or Interpreter Signature	Print Name	Date
Physician/Registered Nurse/Technologist	Print Name and Title	Date