

MRI QUESTIONNAIRE

Cardiac Pacemakers/Defibrillator?	YES	NO
Cochlear or Stapes Implant – ear surgery?	YES	NO
Aneurysm Clips in the brain?	YES	NO
CNS Neurostimulator Device?	YES	NO
Bone Growth Stimulator?	YES	NO
Metal in your eyes?	YES	NO
Worked with metal? (<i>e.g. grinding or welding</i>)	YES	NO
Stent or recent surgery/ metal clips (<i>past eight weeks</i>)?	YES	NO
Heart Valve Prosthesis?	YES	NO
Claustrophobic?	YES	NO
Gunshot wound or BB gun injury?	YES	NO
Body-piercing or jewelry on your body? (<i>If so, please remove prior to MRI</i>)	YES	NO
Hearing aids?	YES	NO
Dentures, removable partials, oral braces or a permanent retainer?	YES	NO
Shunt in your brain, spine or heart?	YES	NO
Metal joints, rods, plates, pins, screws, nails or clips in any part of the body?	YES	NO
Kidney Disease, diabetes or undergoing dialysis? (<i>If so, please circle all that apply</i>)	YES	NO
Asthma or allergic reaction to drugs?	YES	NO
Any surgery?	YES	NO

If so, please list all with dates: _____

FOR WOMEN

Breastfeeding, IUD, diaphragm, or cervical pessary? (<i>If so, please circle all that apply</i>)	YES	NO
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Any possibility that you may be pregnant?	YES	NO
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Date of last menstrual period: _____

FOR MEN

Penile implant? <i>If so, what is the name of the manufacturer?</i> _____	YES	NO
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Patient Signature: _____ Date: _____

Weight: _____ Height: _____