

**MRI SCREENING FORM**

**DATE** \_\_\_\_\_

**SS#** \_\_\_\_\_

Name \_\_\_\_\_ Male \_\_\_ Female \_\_\_  
Last First MI

Age \_\_\_\_ Birthday \_\_\_\_/\_\_\_\_/\_\_\_\_ Height \_\_\_\_ ft. \_\_\_\_ in. Weight \_\_\_\_  
Month Day Year

PROCEDURE \_\_\_\_\_

1. Are you claustrophobic? ..... Yes \_\_\_ No \_\_\_
2. Do you have a cardiac pacemaker, implanted cardiac defibrillator or internal pacing wires? ..... Yes \_\_\_ No \_\_\_
3. Do you have brain or abdominal aneurysm clips (**year, make & model**)? ..... Yes \_\_\_ No \_\_\_
4. Do you have any intravascular stents, filters, or coils? ..... Yes \_\_\_ No \_\_\_
5. Do you have any implants, orthopedic items or hearing aids (**COCHLEAR IMPLANT**) ..... Yes \_\_\_ No \_\_\_
6. Do you have any metal in your body other than dental work? (i.e. metal implant, body piercing, etc.) ..... Yes \_\_\_ No \_\_\_
7. Have you had any shrapnel, BB or gun shot wound or metal sliver in eyes removed? ..... Yes \_\_\_ No \_\_\_  
If yes, what kind: \_\_\_\_\_
8. Are you pregnant or experiencing a late menstrual period? ..... Yes \_\_\_ No \_\_\_
9. Do you have any permanent makeup or eyeliner? ..... Yes \_\_\_ No \_\_\_
10. Are you able to lie still and lie on your back comfortably? ..... Yes \_\_\_ No \_\_\_

\_\_\_\_\_  
Patient Signature