Have you ever had surgery? ☐Yes ☐No
If yes, please list types and dates: _____

Have you had any surgical procedures in the last 6 weeks? ☐Yes ☐No
If yes, please list types and dates: _____

Have you ever worked with metal (grinding, fabrication, machine shop)? ☐Yes ☐No
Have you ever had any metallic objects in your eyes (slivers, foreign body, etc.)? ☐Yes ☐No
If yes, please describe: _____

Do you have any food or medication allergies: ☐Yes ☐No
If yes, please list: _____

Do you have or have you ever had a detached retina (eye)? ☐Yes ☐No
Do you have kidney disease? ☐Yes ☐No
Are you currently undergoing dialysis treatment? ☐Yes ☐No
Have you had or are you scheduled to have a liver transplant? ☐Yes ☐No
Have you had an Endoscopy procedure in the last year? ☐Yes ☐No

For Female Patients: Are you pregnant or experiencing a late menstrual period? ☐Yes ☐No
Are you breast feeding? ☐Yes ☐No
Breast Implants? _____ ☐Yes ☐No

☐Yes ☐No Cardiac Pacemaker (heart)
☐Yes ☐No Implanted Cardiac Defibrillator (heart)
☐Yes ☐No Aneurysm Clip(s) (brain, abdomen)
☐Yes ☐No Carotid Artery Vascular Clamp
☐Yes ☐No Neurostimulator
☐Yes ☐No Insulin or Infusion Pump
☐Yes ☐No Implanted Drug infusion Device
☐Yes ☐No Bone Growth/Fusion Stimulator
☐Yes ☐No Ear Surgery or Implant
☐Yes ☐No Any Type of Prosthesis (eye, penile, etc.)
☐Yes ☐No Heart Valve Prosthesis
☐Yes ☐No Artificial Limb or Joint
☐Yes ☐No Electrode (on body, head, or brain)
☐Yes ☐No Intravascular Stents, Filters, or Coils
☐Yes ☐No Shunt (spinal or intraventricular)
☐Yes ☐No Vascular Access Port and/or Catheter
☐Yes ☐No Swan-Ganz Catheter
☐Yes ☐No Any Implant Held in Place By a Magnet

☐Yes ☐No Transdermal Delivery System (NITRO)
☐Yes ☐No IUD or Diaphragm
☐Yes ☐No Tattooed Makeup (eyeliner, lips, etc.)
☐Yes ☐No Body Piercing(s)
☐Yes ☐No Any Metal Fragments
☐Yes ☐No Internal Pacing Wires (heart)
☐Yes ☐No Metal or Wire Mesh Implants
☐Yes ☐No Wire Sutures or Surgical Staples
☐Yes ☐No Harrington Rods (spine)
☐Yes ☐No Joint Replacement _____
☐Yes ☐No Bone/Joint Pin, Screw, Nail, Wire, Plate
☐Yes ☐No Hearing Aid (Remove before MRI)
☐Yes ☐No Dentures (Remove before MRI)
☐Yes ☐No Breathing Disorder
☐Yes ☐No Claustrophobia or Anxiety
☐Yes ☐No Blood/Body Fluid/Infection Control Precautions (TB/MRSA, etc.)

I attest that the above information is correct to the best of my knowledge. I read and understand the contents of the form and had the opportunity to ask questions regarding the information on this form and regarding the MR procedure that I am about to undergo.

_____ _____
Patient/Health Care Agent/Surrogate Decision Maker Signature Date/Time

_____ _____
Interpreter Signature (If Required) Date/Time

_____ _____
History Reviewed By Signature Date/Time

_____ _____
Reviewing Technologist Signature Date/Time

MR Technologist Worksheet and MR Screening Sheet