

Every patient scheduled for an MRI Exam **MUST** complete the following questionnaire prior to being scanned.
 Please answer each question accurately and explain any marked "yes".

Patient's last name	Patient's first name	Date of birth (yyyy/mm/dd)
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Weight: kg	Height: cm	Please identify any special needs (i.e., sight, hearing impairment, interpreter etc.):
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Known allergies:

WARNING: If you plan on taking a sedative, you must have a driver with you or the exam will be cancelled. We ask that you remove all body piercings, jewelry, watches etc. before arriving to the MRI site. Certain implants, devices or objects may be hazardous to you or may interfere with the MRI procedure.

Please fill out the Screening Form as accurately as possible.	Yes	No	If YES, what, where, when (if applicable)
Do you have a cardiac pacemaker?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have an implanted defibrillator (present or past)?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you had heart surgery (valve replacement, bypass etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have implanted clips, stents, coils, filters, grafts?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you had surgery for an aneurysm?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have an electronic implant, wires or device, pump, stimulator?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you had ear or eye surgery?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you had an eye (ocular) injury?	<input type="checkbox"/>	<input type="checkbox"/>	
Are you on dialysis?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have implanted shunts, port-a-cath, catheter, Hickman, Swan Ganz, electrodes?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have an artificial implant (eye, penile etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	
Any type of prosthesis or metal in your body?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you had a colonoscopy or endoscopy within the last 6 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have diabetes or seizures, Lupus, history of kidney or heart disease, TIA, high blood pressure (hypertension), stroke or poor circulation to the legs or other parts (excluding varicose veins)?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have implanted shrapnel, bullets or pellets?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you had a transplant?	<input type="checkbox"/>	<input type="checkbox"/>	

Please indicate Yes or No to any of the following:

	Yes	No		Yes	No		Yes	No
Are you claustrophobic?	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had an MRI scan before?	<input type="checkbox"/>	<input type="checkbox"/>	Radiation seeds?	<input type="checkbox"/>	<input type="checkbox"/>
Are you prone to falls?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, were you injected with contrast?	<input type="checkbox"/>	<input type="checkbox"/>	Surgical rods, pins, screws or plates?	<input type="checkbox"/>	<input type="checkbox"/>
Any mobility issues?	<input type="checkbox"/>	<input type="checkbox"/>	Taking beta blockers?	<input type="checkbox"/>	<input type="checkbox"/>	Motion disorder?	<input type="checkbox"/>	<input type="checkbox"/>
Medication patches?	<input type="checkbox"/>	<input type="checkbox"/>	Tattoo or permanent makeup?	<input type="checkbox"/>	<input type="checkbox"/>	Metallic cosmetics?	<input type="checkbox"/>	<input type="checkbox"/>
Cochlear, hearing aid or ear implant?	<input type="checkbox"/>	<input type="checkbox"/>	Body piercing, jewelry?	<input type="checkbox"/>	<input type="checkbox"/>	Joint replacements?	<input type="checkbox"/>	<input type="checkbox"/>
Dentures or partial plates?	<input type="checkbox"/>	<input type="checkbox"/>	Currently on chemotherapy?	<input type="checkbox"/>	<input type="checkbox"/>			

For female patients:	Yes	No		Yes	No
Post-menopausal? If yes, date of last menstrual period (yyyy/mm/dd):	<input type="checkbox"/>	<input type="checkbox"/>	Are you currently breastfeeding?	<input type="checkbox"/>	<input type="checkbox"/>
Are you pregnant or the possibility of being pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have an IUD or diaphragm?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have breast implants, breast tissue expanders or pessary?	<input type="checkbox"/>	<input type="checkbox"/>			

The above information is correct to the best of my knowledge.

Name of person completing form or assisting patient (print)	Signature	Date (yyyy/mm/dd)
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Form completed by: <input type="checkbox"/> Patient <input type="checkbox"/> Relative <input type="checkbox"/> Power of Attorney	Relationship to patient:
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