



MRI Safety Questionnaire

Patient Name _____ Weight _____ Date _____
 (last) (first) (lbs.)

- Have you ever had an injury to the eye involving a metallic object, e.g. metal slivers, shavings or foreign bodies? Yes _____ No _____
- Are you pregnant or is there a possibility that you may be pregnant? Yes _____ No _____
- Are you breast-feeding? Yes _____ No _____
- Do you have a history of cancer? Yes _____ No _____
- Do you have sickle-cell anemia or Wilson’s disease? Yes _____ No _____
- Have you ever had a reaction to Gadolinium (MRI contrast)? Yes _____ No _____
- Did you bring in any previous studies pertaining to today’s visit? Yes _____ No _____

If yes, explain below:

Some of the following items may be hazardous to your safety or may interfere with the MRI study. Please check the correct answers as they pertain to you.

YES NO

Cardiac Pacemaker		
Implanted Cardiac Defibrillator		
Implanted Neurostimulator		
Implanted Drug Infusion Pump		
Aneurysm Clips		
Spinal Stimulator Device		
Cochlear Implants		
Penile Implant		
IUD		
Heart Valve Prosthesis		
Artificial Limbs or Joints		
Tattooed Eyeliner or Eyebrows		
Body Piercing (other than ears)		
Other Implants in Head		
Shunt		
Stent		

YES NO

Harrington Rods		
Metal Screws or Plates		
Dentures		
Wires, Sutures or Staples		
Shrapnel or Bullets		
Coils or Filters		
Claustrophobia		

List any items in your body that were not listed above.
