GUILFORD RADIOLOGY
Imaging Excellence with Personalized Care
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MRI Screening Questionnaire

Patient Name:____ Date of Birth: ____________

Height: ___________ Weight:___________

YES NO Do you have a **cardiac pacemaker**, **defibrillator,** or **wires** still in place?

YES NO Have you had a **coronary bypass** or **artificial heart valves**?

YES NO Have you had any type of **stents, clips, coils, or filters**?

YES NO Have you had **brain surgery (aneurysm clip, programmable shunt)**?

YES NO Do you have **metallic implants? plates, screws, pins, anchors,** or **wires**?

If YES, describe: ____

YES NO Do you have a **neurostimulator**, **electronic implant, or drug pump**?

YES NO Do you have any type of **artificial limb or joint**?

YES NO Do you have any type of **prosthesis (penile) or tissue expander**?

YES NO Have you had any **eye surgery/artificial eye or eyelid spring**? Type: _________________ Date: _________________

YES NO Have you had a **shrapnel (metal**) or **gunshot/BB gun** injury **eyes, head**, or **skin**?

YES NO Do you have **braces, dentures**, or a **retainer**? Permanent _____Removable _____

YES NO Do you have a **hearing aid/color contact**?

YES NO Do you have any **body piercings**?

YES NO Have you gotten any **tattoos** or **permanent makeup** (**within 4-wks**)?

YES NO Do you wear a **wig** or **hair extensions** with **micro beads/clips**?

YES NO Do you have an **insulin pump**?

YES NO Do you have an **IUD**, **Diaphragm**, or **Pessary Ring**?

YES NO Do you have any **pain/medication/hormone** patches on?

YES NO Are you **pregnant** or suspect you may be pregnant?

YES NO Do you have an **allergy to MRI contrast**?

YES NO Are you able to **walk**, get **changed**, and **on/off the table without assistance**?

YES NO Have you had any **surgery in your lifetime**?

If YES, **list all surgeries** below: ____

YES NO Have you had any **surgical procedures** to the **body part being imaged**?

If YES, describe: ____

Have you had any of the following tests related to the body part we are screening today?

- ☐ X-Rays Date of Scan:_________________Facility Name: ______________________________
- ☐ CT Scan Date of Scan:_________________Facility Name: ______________________________
- ☐ MRI Scan Date of Scan:_________________Facility Name: ______________________________
- ☐ U/S Date of Scan:_________________Facility Name: ______________________________

I attest that the above information is true to the best of my knowledge. I have read and understand the entire contents of this form and have had the opportunity to ask questions regarding this information.

Signature:____Relation to patient:____________________

Technologist signature: ____________________________________Date: ____________________________