GUILFORD RADIOLOGY
Imaging Excellence with Personalized Care
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MRI Screening Questionnaire

Patient Name: ____ Date of Birth: ____________________

Height: ____________ Weight: _____________

1. Do you have a cardiac pacemaker? ☐ Yes, Please provide card ☐ No
2. Do you have any aneurysm clips in your head or neck? ☐ Yes, Please provide card ☐ No
3. Have you EVER had HEART or BRAIN surgery? ☐ Yes ☐ No If yes, describe: ________________________
4. Do you have any metallic, mechanical or electronic implants or foreign bodies anywhere in your body? ☐ Yes ☐ No
   If yes, describe: ____
5. Have you EVER had any eye or ear surgery? ☐ Yes ☐ No If yes, describe: ________________________
6. Have you ever had a metal injury to your eye that penetrated? ☐ Yes ☐ No How was it removed? __________
7. Have you ever had a surgical procedure to the body part that is being imaged? ☐ Yes ☐ No
   If yes, please list: ____
8. 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: ____________________
9. Is there any chance you could be pregnant? ☐ Yes ☐ No
10. Are you a nursing mother? ☐ Yes ☐ No
11. Are you claustrophobic? ☐ Yes ☐ No

For Contrast:

12. Do you have an allergy to MRI contrast? ☐ Yes ☐ No

The following items can interfere with MR imaging and some may be hazardous to your safety.
Please check the appropriate box for each of the following items:

Do you have a cardiac pacemaker? ☐ Yes ☐ No
Do you have any aneurysm clips in head or chest? ☐ Yes ☐ No
Have you EVER had HEART or BRAIN surgery? ☐ Yes ☐ No
Any other implants of ANY kind? ☐ Yes ☐ No If yes, describe: ____________________
Insulin Pump? ☐ Yes ☐ No
Dentures or hearing aids? ☐ Yes ☐ No

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: ________________________

Signs and symptoms: ____