



## Magnetic Resonance Checklist

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Weight: \_\_\_\_\_

Chief Complaint: \_\_\_\_\_

**Patient History (please answer all questions)**

	YES	NO
1. Have you had any recent lab work?		
2. Is there any chance that you are pregnant?		
3. Do you have a heart pacemaker, pacing wires, defibrillator, or metal valves?		
4. Do you any heart stents? Date of placement     /     /		
5. Do you have any of the following?		
Defibrillator?		
Aneurysm or vascular clip?		
Intra-cranial by-pass clips or shunts?		
Middle ear prosthesis (cochlear implants), hearing aids		
Neurostimulator (tens unit)		
Vena Cava filter (umbrella)		
Shrapnel, metallic splinters, or other foreign bodies?		
Bio- stimulator?		
Tattoos, permanent eyeliner, wig, or hairpiece?		
Surgical prosthesis (joint replacement) or metal implants?		
Infusion pump?		
History of gun shot wound?		
Penile prosthesis?		
Probe or capsule for heart burn or acid reflux?		
Date of surgery     /     /		
Body piercings? Please remove before procedure.		
6. Have you ever had any eye injuries?		
7. Have you ever been employed as a welder, or worked in an auto body shop, or metal shop, or worked with metal as a hobby where contact with metal shavings was possible or likely?		

**TURN OVER PLEASE**

8. Have you ever had cancer? If yes what type and when was It discovered?		
9. Have you ever had radiation therapy or chemotherapy? If yes, when was Your last treatment?     /     /		
10. Have you had any type of surgery? Please list type and dates:		
11. Have you ever been diagnosed with hypertension (high blood pressure)?		
12. History of chronic renal disease?		
13. Do you have diabetes?		
14. Do you have liver disease or a liver transplant?		
15. Do you have any known allergies, including allergies to medications and contrast dyes?		
16. Have you had a previous MRI scan? When and where?		
17. Have you had a previous CT scan? When and where?		
18. Have you had previous X-rays? When and where?		

**You may not enter the scan room with any of the following objects: steel toed shoes/boots, stimulator, infusion pump, pacemaker, defibrillator, hairpins, barrettes, hearing aid, safety pins, dentures, jewelry, pocket knife, belt, glasses, wallet, keys, credit cards, ink pens, beepers, weapons, watch, medication patches (nicotine, hormone, pain, or other), or any other metal items. The above items may result in injury to the patient, as well as the technologist and the equipment.**

I have read and fully understand this questionnaire.

Patient Signature: \_\_\_\_\_ Date \_\_\_\_\_  
(or authorized representative)

Relationship to Patient: \_\_\_\_\_