Patient Name: Chart Number:

# TRUE MEDICAL IMAGING MEDICAL QUESTIONNAIRE MRI CHECK LIST

**We will be placing you in a large OPEN magnet; you will hear a “knocking” which will persist while the test is being performed.**

**This checklist is for you safety. Some of these items might make it hazardous for you to enter a strong magnetic field. If you are unsure of an answer, please let the receptionist and/or technologist know and they will be happy to answer any questions you may have with this questionnaire.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Do you have the following?**  Brain Shunt | Yes\_ | No\_ | Hair Extensions | Yes\_ | No\_ |
| Neurostimulators | Yes\_ | No\_ | Permanent eye lining/Tattooing | Yes\_ | No\_ |
| Hearing Aids | Yes\_ | No\_ | Joint Replacement | Yes\_ | No\_ |
| Ear Prosthesis (Cochlear Implant) | Yes | No | Fractured Bones Replacement | Yes\_ | No\_ |
| Aneurysm Clips for Brain Surgery Cardiac pacemaker  Coronary Artery Clips | Yes Yes\_ Yes\_ | No \_ No\_ No\_ | Metal Rod, Screws Pins or Nails | Yes | No \_ |
| Heart Valve Replacement Bypass Surgery Implanted Defibrillator Insulin Pump  Any Implanted Electronic Device Worked as a Metal Worker Worked as a Lock Smith | Yes\_ Yes\_ Yes\_ Yes\_ Yes\_ Yes\_ Yes\_ | No\_ No\_ No\_ No\_ No\_ No\_ No\_ |  |  |  |
| Worked as a Key Maker Worked as a Welder  Had an Injury to either eye | Yes\_ Yes\_ Yes\_ | No\_ No\_ No\_ |  |  |  |

If yes, explain:

\_

**Any personal history of:**

Headaches Yes

Dizziness Yes

Seizure disorder Yes

Stroke Yes

Heart Disease Yes

Asthma Yes

Allergic Respiratory Disease Yes\_ Chronic Obstructive Pulmonary Disease (COPD) Yes

No No No No No No No No

Multiple Myeloma Yes \_ No \_ Blood disorder/Sickle Cell Yes \_ No \_ HIV Positive Yes \_ No \_

Diabetes Yes\_ No

Liver Disease Yes\_ No

Renal Failure Yes \_ No

Kidney/Bladder disease Yes \_ No

Prostate Problems Yes \_ No

Hepatitis Yes \_ No

If yes, what type: \_

Explain:

Please sign below to confirm that you fully understand this questionnaire and that you are able to answer every question.

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Patient/Guardian signature Date

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