



# Beth Israel Deaconess Medical Center

Boston, MA 02215

PATIENT'S NAME \_\_\_\_\_

MED. REC. # \_\_\_\_\_

DOB \_\_\_\_\_

Patient Identification

## MRI OUTPATIENT SCREENING QUESTIONNAIRE

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient's Name: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_

An MRI uses a very strong magnet to take pictures of the inside of the body. For your safety, we need to know if you have any metallic objects in or on your body **before** you enter the exam room. Please place a check in the "Yes" or "No" box for each item below. Give us as much information as possible about any implanted devices.



	Yes	No		Yes	No
1. Pacemaker / Pacer wires / Implantable defibrillator Make / Model #: _____ Date of surgery: ____/____/____			16. Are you wearing a patch that delivers medication?		
2. Intracranial or brain aneurysm clip (brain surgery) Make / Model #: _____ Date of surgery: ____/____/____			17. Have you ever had trouble getting an IV put in?		
3. Have you had an MRI before? <b>If Yes</b> , did you receive a contrast injection?			18. Have you had a colonoscopy, endoscopy or interventional procedure in the last 30 days?		
4. Have you had an MRI in the past 7 days? <b>If Yes</b> , did you receive a contrast injection?			19. Do you have an implanted port or indwelling catheter? <b>If Yes</b> , what type of port or catheter: _____		
5. Metallic heart valve or any metallic stents Make / Model #: _____ Date of surgery: ____/____/____			20. Implanted pump (insulin, pain med, chemotherapy) Type of pump: _____ Where is the pump: _____		
6. Bio or neurostimulator, electronic device or implant Make / Model #: _____ Date of surgery: ____/____/____			21. Are you on dialysis? <b>If Yes</b> , how often: _____		
7. Tattoo(s), Tattooed eyeliner <b>If Yes</b> , where: _____			22. Please <b>list</b> all surgeries and dates: _____/____/____ _____/____/____ _____/____/____ _____/____/____		
8. Body piercing <b>If Yes</b> , where: _____			23. Please <b>check</b> if you have any of the following medical conditions: <input type="checkbox"/> Asthma / Hay fever <input type="checkbox"/> Heart Disease <input type="checkbox"/> Multiple Myeloma <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Pheochromocytoma <input type="checkbox"/> Sickle Cell Disease		
9. Metal injury to the eye requiring medical attention <b>If Yes</b> , date of injury: ____/____/____			<b>FEMALES ONLY:</b>	Yes	No
10. Shrapnel (metal in body) <b>If Yes</b> , where: _____			24. Is it possible that you may be pregnant?		
11. Ear surgery or prosthesis Date: ____/____/____ Type or Model: _____			25. Intrauterine Device (IUD) or Diaphragm Type or Model: _____		
12. Eye surgery or prosthesis Date: ____/____/____ Type or Model: _____			26. Pessary (in pelvis)		
13. Limb or joint replacement or pinning Where: _____			<b>MALES ONLY:</b>	Yes	No
14. Tissue expander (e.g. breast implant)			27. Do you have a penile implant? <b>If Yes</b> , make and model: _____		
15. Are you having an endoscopy study right now which uses a small pill camera?					

### MRI Staff will speak to you about the need for removing the following items:

Removable dental work | Eyeglasses | Wallet / keys | Watch / Jewelry | Credit and ATM (Automated Machine) cards | Hearing aids | Wigs / hairpieces or bobby pins

**X** \_\_\_\_\_ or **X** \_\_\_\_\_ and \_\_\_\_\_  
Patient's Signature Person authorized to sign for patient Relationship to patient

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Time: \_\_\_\_:\_\_\_\_:\_\_\_\_  a.m.  p.m.

**X** \_\_\_\_\_  
Nurse or Technologist Signature Print Name Date Time (24 hour)

