



MRI Safety Questionnaire/Consent Form

Patient Name: _____ Doctor: _____ Date: _____

Weight _____

	YES	NO		YES	NO
Ear/Body piercings (if yes remove)	<input type="checkbox"/>	<input type="checkbox"/>	History of Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Aneurysm Clip	<input type="checkbox"/>	<input type="checkbox"/>	History of Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Gunshot wound/ Shrapnel	<input type="checkbox"/>	<input type="checkbox"/>	Known/Possible Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Aid (If yes, remove)	<input type="checkbox"/>	<input type="checkbox"/>	Breastfeeding	<input type="checkbox"/>	<input type="checkbox"/>
Wig/Weave	<input type="checkbox"/>	<input type="checkbox"/>	History of Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Neurostimulator	<input type="checkbox"/>	<input type="checkbox"/>	History of Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Surgery within last 2 months	<input type="checkbox"/>	<input type="checkbox"/>	Previous MRI at MIND	<input type="checkbox"/>	<input type="checkbox"/>
Penile Prosthesis	<input type="checkbox"/>	<input type="checkbox"/>	Do you weigh more than 350 lbs?	<input type="checkbox"/>	<input type="checkbox"/>
Medication Skin Patches	<input type="checkbox"/>	<input type="checkbox"/>			
Metal rods/plates/Screws	<input type="checkbox"/>	<input type="checkbox"/>	List ALL surgical procedures:		
Cochlear Implant	<input type="checkbox"/>	<input type="checkbox"/>	<div style="border: 1px solid black; height: 60px; width: 100%;"></div>		
Pacemaker/Defibrillator	<input type="checkbox"/>	<input type="checkbox"/>			
Insulin/Infusion Pump	<input type="checkbox"/>	<input type="checkbox"/>			
Heart Valve Prosthesis	<input type="checkbox"/>	<input type="checkbox"/>			

Is current problem injury related? YES NO If yes, please describe injury including date of injury.

Do you have a history of cancer? YES NO If yes, please describe.

Please describe your current symptoms (Do not leave blank)

Do you require special assistance getting on MRI table? YES NO
Is there any other item/device/issue you believe we should be informed of prior to MRI scan? YES NO
If yes, please describe.

Please remove all metallic objects before MRI scan such as keys, hairpins, cell phones, pocket knives, credit cards, guns, etc. These objects can interfere with your scan, and possibly be dangerous.

Signature: _____ Date: _____