MRI Safety Questionnaire

1. Cardiac pacemaker/valve prosthesis? □ YES □ NO

2. Any stents in your body? □ YES □ NO
   If so, where in the body ____________________
   Facility that put them in____________________

3. Cerebral aneurysm clip? □ YES □ NO

4. Any known metal in body? □ YES □ NO
If "yes" please explain and give
   date of when placed (dental fillings ok) ________________________

5. Nerve stimulation device? □ YES □ NO
6. Implanted pumps/devices? □ YES □ NO
7. Cochlear/middle ear implant? □ YES □ NO

8. Have you ever had an eye injury with metal? □ YES □ NO
   If "yes", were orbit x-rays taken: ___________
   Date/Place where orbits done: _____________________

9. Approximately how much do you weigh? _______________

10. Do you have a history of kidney disease? □ YES □ NO
11. Do you have a history of high blood pressure? □ YES □ NO
12. Do you have a history of diabetes? □ YES □ NO
13. Do you have a history of liver disease? □ YES □ NO

14. Is this scan for a specific event or injury? □ YES □ NO
    If so, History/date of injury
    ____

15. Do you have any relevant surgeries: □ YES □ NO
    If so, History/Date of surgery ___________________

16. Please list current medications: _____________________________________

    ____

<u>If you are female</u>, please answer questions 17-19:

17. Is there a <u>chance</u> that you are pregnant? □ YES □ NO

18. Do you have an IUD? □ YES □ NO
    If so Make ___________/ Model_____________

19. Date of last menstrual Cycle ______________

Date: _____________ Signature ________________