TOWER RADIOLOGY

MRI/MRA SAFETY SCREENING QUESTIONNAIRE

Name: _____ **Date:** _____
Sex: M F **Age:**_____ **Height** _____**Weight:**_____ **Referring Doctor:**_____
Type of MRI/MRA:_____
Reason for visit:_____

IT IS IMPORTANT FOR YOU TO ANSWER ALL OF THE FOLLOWING QUESTIONS BELOW:

PACEMAKER	Yes	No	Metal / Plates	Yes	No
DEFIBRILLATOR	Yes	No	Neurostimulator / Biostimulator	Yes	No
LOOP RECORDER	Yes	No	Surgical Clips / Staples / Nails	Yes	No
Heart Surgery Year:_____	Yes	No	IUD / Diaphragm / Pessary	Yes	No
Heart Valve / Stent / Coils / Filters / Shunt	Yes	No	Penile Implant	Yes	No
Brain Surgery	Yes	No	Prior Vascular Surgery	Yes	No
Aneurysm Clips	Yes	No	Medication Patch (Nitro, Nicotine, Etc.)	Yes	No
Hearing Aids	Yes	No	Radiation Therapy / Seed Implant	Yes	No
Middle Ear Implant	Yes	No	Wig / Hair Implants or Extensions	Yes	No
Eye Implant / Eyelid Spring	Yes	No	Body Piercings	Yes	No
Injury to the eye involving metal	Yes	No	Safety Pins In Clothing	Yes	No
Implanted drug Infustion pump/Insulin pump/electrodes	Yes	No	Bobby Pins in Hair	Yes	No
Gunshot wounds, shrapnel, BB's	Yes	No	Resolution Clips (Revision gastric bypass)	Yes	No
Any electrical, mechanical or magnetic implants	Yes	No	Tattoos / Permanent Makeup	Yes	No

Are you claustrophobic? _____
Have you ever worked with or around metal (welding, grinding, sheet metal cutting)?_____
Have you ever been diagnosed with Cancer or Tumor? When/Where? _____
Previous Spine Surgery (Cervical, Thoracic or Lumbar)? When/Where? _____
Any history of kidney disease or dialysis? If yes, explain: _____
List all previous surgeries:
_____
_____
_____

I attest that the above information is correct to the best of my knowledge. I have read and understand the contents of this form. I have had the opportunity to ask questions regarding information on this form.

_____ _____
Patient/Parent/Legal Guardian Date

_____ _____
Technologist Date

NATIONAL HARBOR
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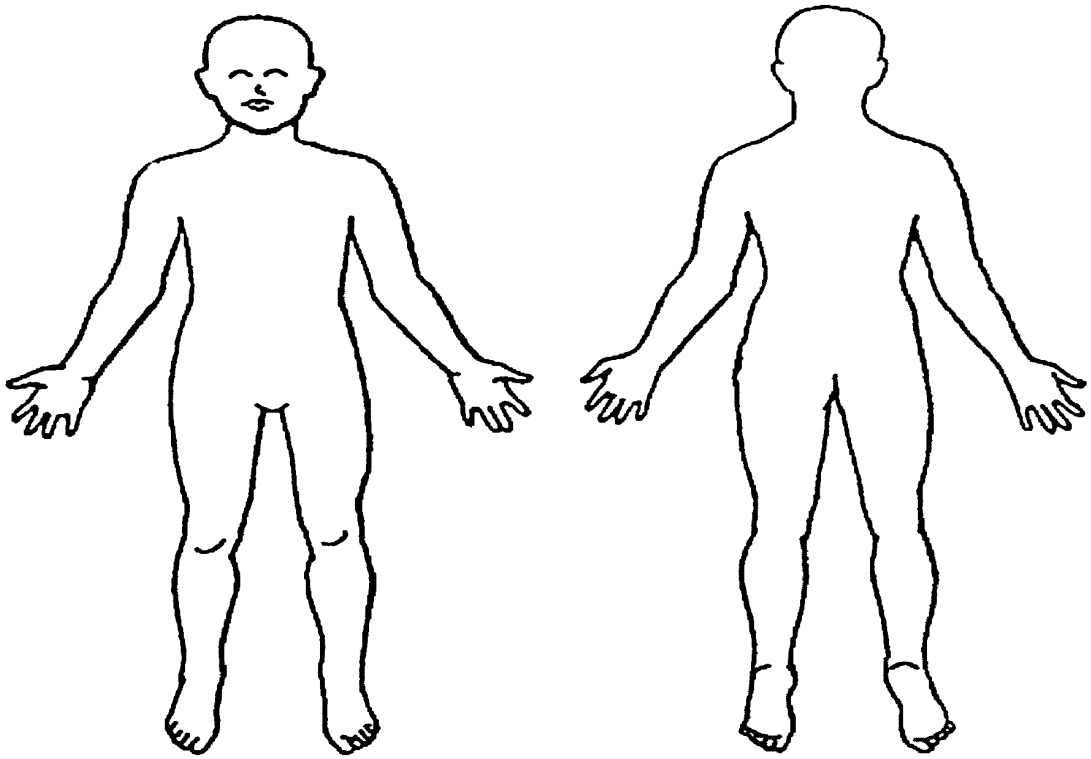
Please circle the area of pain/ discomfort on the drawing below, indication symptoms with the below letters:

KEY: D: Dull ache S: Sharp pain N: Numbness T: Tingling



Please describe your present symptoms:

_____

_____

_____

What do you think might have caused the problem and when did it start:_____

_____

_____

Have you had any surgery on the part of the body that we are scanning today: _____

If yes:

Date	Type of Surgery	Name of Surgeon
_____	_____	_____
_____	_____	_____

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