

Patient's Name: _____

Date of birth: _____

Today's date: _____

Please read the following questions carefully. It is very important for us to know if you have any **metal devices** or **metal parts** anywhere in your body. If you do not understand a question on this form, please ask us to explain! If you have any questions about MRI safety, please call (203) 688-5739.

Please complete BOTH sides of this form

1. **Yes** **No** Do you have a heart pacemaker? (if you have a pacemaker, **you cannot have an MRI**)
2. **Yes** **No** Did you ever have a device implanted somewhere in your body like a heart defibrillator?
3. **Yes** **No** Did you ever have an aneurysm clip implanted during brain surgery?
4. **Yes** **No** Do you have nerve stimulators (neuro-stimulators also called TENS or wires)?
5. **Yes** **No** Do you have any devices to make bones grow (like bone growth or bone fusion stimulators)?
6. **Yes** **No** Do you have implants in your ear (like cochlear implants)?
7. **Yes** **No** Do you have a Vagus nerve stimulator to help you with convulsions or with epilepsy?
8. **Yes** **No** Do you have a filter for blood clots (Umbrella, Greenfield, bird's nest)?
9. **Yes** **No** Do you have embolization coils (Gianturco) in your brain?
10. **Yes** **No** Do you have implants in your eyes?
11. **Yes** **No** Do you have any stents (small metal tubes used to keep blood vessels open)?
12. **Yes** **No** Do you have an implanted pump to deliver medication?
13. **Yes** **No** Do you have an artificial arm or leg?
14. **Yes** **No** Do you wear a patch to deliver medicines through the skin?
15. **Yes** **No** Do you have shrapnel or metal in your head, eyes or skin?
If you do, where? _____
16. **Yes** **No** Have you ever had metal in your eyes removed by a doctor?
17. **Yes** **No** Have you ever had a gunshot wound?
18. **Yes** **No** Do you have body-piercing or jewelry on your body?
19. **Yes** **No** Do you use a hearing aid?

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- 20. Yes No Do you wear braces on your teeth?
- 21. Yes No Do you have a “shunt” (a tube to drain fluid) in your brain, spine or heart?
- 22. Yes No Do you have metal joints, rods, plates, pins, screws, nails or clips in any part of your body?
- 23. Yes No Do you have a tattoo? (We need to make sure it does not heat up during the MRI)
- 24. Yes No Do you get upset or anxious in small spaces?
- 25. Yes No Have you ever had an allergic reaction? If yes, to what? _____
- 26. Yes No Have you ever had heart or brain surgery? What kind of surgery? _____
- 27. Yes No Can you walk without help?
- 28. Yes No Are you a diabetic?
- 29. Yes No Do you have only one kidney or have you had a kidney transplant?
- 30. Yes No Do you have any problems with your kidneys?
- 31. Yes No Do you have high blood pressure (hypertension)?
- 32. Yes No Are you on dialysis?
- 33. Yes No Do you have liver disease?
- 34. Yes No **For women:** Are you breastfeeding?
- 35. Yes No **For women:** Do you use a diaphragm, IUD, or cervical pessary?
- 36. Yes No **For women:** Do you think there is any possibility that you are pregnant?
- 37. Yes No **For men:** Do you have implants in your penis?

How much does the patient weigh? _____

Name of the person who completed the form: _____

Signature: _____

Date: _____

For Department of Radiology use only. DO NOT WRITE BELOW.

Contrast used: <input type="checkbox"/> Magnevist <input type="checkbox"/> MultiHance <input type="checkbox"/> Feridex Volume (cc): _____ IV x 1 for Technologist: _____ Date: _____ CD authorization: <input type="checkbox"/>	Creatinine: _____ eGFR: _____
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