Portsmouth Regional Hospital

MRI Safety Questionnaire

Name: _____ ☐ Male ☐ Female Weight: _____lbs.

Have you ever had:

An MRI before? When _____ Where_____ Body Part_____ ☐No ☐Yes

Any other studies for today's problem? If so what? _____ ☐No ☐Yes

Surgery in the last 6 weeks? What: _____ ☐No ☐Yes

Injury to your eyes involving metal or prior experience as a metal worker? ☐No ☐Yes

Are you:

Pregnant or breast feeding? ☐No ☐Yes

Claustrophobic (fearful of enclosed spaces)? ☐No ☐Yes

Do you have? (check boxes that apply)

□ Personal history of Cancer Type:_____ □ Sickle cell anemia □ Diabetes □ One kidney or Kidney disease □ Dialysis treatment □ Asthma/allergic respiratory disease	□ **Pacemaker (or residual wires from a pacemaker)** □ Heart Valves □ Carotid Artery Vascular clamps □ Intravascular stents, filters or coils	□ **Brain Aneurysm clips, plates or shunts in your head** □ Cochlear Implants (ear, stapes, prosthesis ect.) □ Hearing Aids □ History of seizure
□ PH monitoring system in esophagus or small bowel capsule endoscopy □ Endoscopic procedure where hemostatic clips were placed When placed?_____ Doctor?_____ □ **Implanted drug infusion pump**	□ Artificial limbs or joints Where?_____ □ Metal plates, rods or pins Where?_____ □ Implant held in place by a magnet □ Prosthesis (eye, penile) □ **Implanted neurostimulator** □ **Bone growth stimulator**	□ Tattoos (may cause heating, irritation. Inform technologist of any discomfort.) □ Piercings □ Bullets, BB's or shrapnel □ Transdermal patch □ Any other type of implants in your body that have not been listed? _____ _____

NOTE: Patients will be asked to empty their pockets and inform the technologist if they are wearing dentures, hearing aids, safety or hair pins, or a watch. Make sure your pockets are completely empty including wallet and plastic cards.

YOU MAY NOT ENTER THE MRI ROOM WITH:

Pacemakers Implant Drug Infusion Pumps Cochlear Implants (ear, stapes, prosthesis ect.)
Brain Aneurysm Clips Loose Metal Objects Implanted neurostimulater Bone Growth Stimulators

Patient Signature: _____ Date: _____

Reviewed By: _____ Date: _____ Time: _____

Patient Information/Label

**RADS* PRH734001 rev 1/11*