



E-Z MRI SCREENING FORM

Name _____ Weight _____

Do you have any of the following:

Pacemaker Y N

Implanted cardiac defibrillator Y N

Brain aneurysm clip(s) or other vascular clip(s) Y N

Cochlear (inner ear) implant(s) Y N

Ocular (eye) implant(s) Y N

Cardiac stents *If yes, date of placement _____ Y N

Heart valve Y N

Coils, filters or shunts Y N

Transdermal patches (nitro or other) Y N

Tattoos Y N

*Any history of cancer Y N

*Any history of diabetes Y N

*Any history kidney disease Y N

*Are you on dialysis Y N

(Metal workers only)

Exposure of metal to eyes Y N

Always worn eye protection Y N Sometimes

Metal fragment(s) removed from eyes by a physician Y N

(Women only)

Are you pregnant? Y N Not Sure

Wearing an IUD or diaphragm Y N

Breastfeeding Y N

Claustrophobic Y N Not Sure

List surgeries that you've had and years you had them:

Overall final check

Any other metal, implants of any kind, or electronic devices Y N

within or around the body (orthopedic metal such as pins, screws, plates, joint replacements, breast tissue expanders, staples, drug infusion pumps, shrapnel or other metal from a firearm injury, electronic stimulators, body piercings...)?

If "yes" to above question, please list and specify: _____

I hereby verify that the questions answered are accurate to my knowledge:

Signature of person completing form

date

reviewed by

***Signature is mandatory before entry into magnet